Royal Shrewsbury Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of acute hospital services for Shropshire, Telford & Wrekin and mid Wales. The trust provides care from multiple locations, but there are two main hospital sites, which are The Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury.

We carried out an unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital on 16 April 2019, to review the assurances we had received relating to conditions imposed on the trust's registration following inspection in August 2018. The conditions imposed on the registration included:

- The registered provider must ensure that there is an effective system in place to ensure effective and continued clinical management for low and high-risk patients who present to the midwifery services in line with national clinical guidelines. This includes cardiotocography (CTG), Modified Early Obstetric Warning System (MEOWS), reduced foetal movement and triage guidelines. The provider must ensure that trust guidelines include a clear escalation plan to secure timely review from medical staff.
- From 14 September 2018 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing the system in place for effective clinical management of patients presenting at the midwifery services at The Princes Royal and Royal Shrewsbury Hospitals. The report must include the following:
- The actions taken to ensure that the system is implemented and effective.
- The actions taken to ensure the system is being audited and monitored and continues to be followed.
- The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place, and patients are escalated appropriately for medical support and review in line with national clinical guidelines.

We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology and inspected specific key lines of enquiry within the safe and well led domains.

We met members of the maternity team on duty whilst on site. We looked at the environment, reviewed care records and other documentation.

During our inspection, we spent time on the midwife led unit to ensure improvements had been made to ensure it was safe and fit for purpose. We reviewed midwifery staffing levels to see if they had improved to meet the needs of women and ensure women and babies were safe. There were plans to improve staffing levels, however, they had not been fully implemented which meant there continued to be staffing concerns at the unit.

We reviewed National Institute of Health and Care Excellence (NICE) operational policies and guidelines to ensure they were reviewed and in date. Policies and guidelines documentation had improved; however, staff did not use the updated National Early Warning Score (NEWS 2) which had been revised by The Royal College of Physicians in December 2017. The deadline for NHS providers to adopt the tool was by March 2019. This meant they were not using the most up to date version to keep women safe.

We also checked midwives followed policy and had safety devices when working alone. For example, mobile phones to allow flexibility of access to patient information as well as for use as a lone working device to keep staff and women safe. This continued to be of concern because the system had not been fully implemented

Summary of findings

We found improvements in managing women with higher risks in pregnancy. We checked that women at high risk were appropriately escalated and received a medical review without delay. Women with high risks relating to their birth were seen at the Princess Royal Hospital. This process ensured that early escalation of risk was identified and reviewed by senior midwives and medical staff. We checked policies on reduced foetal movements so there was a clear and defined pathway for midwives and sonographers to follow.

There were areas of poor practice where the trust must make improvements.

Action the trust MUST take to improve:

- The trust must ensure midwife staffing is improved to ensure women receive safe and high-quality care and treatment.
- The trust must ensure all risks are assessed, managed and mitigated through good governance systems and in line with up to date guidance.

Action the trust SHOULD take to improve:

- The trust should ensure the birthing room is adequately staffed and has timely access to the right equipment to ensure women had the choice to use the rooms safely.
- The trust should ensure staff receive appropriate leadership to support them in running a safe and effective service to people who chose the unit for their needs.
- The trust should use the latest version of the National Early Warning Score (NEWS), which was updated in December 2017.
- The trust should ensure staff have access to mobile phones to allow flexibility of access to patient information as well as for use as a lone working device to keep them safe.

We took enforcement action at Royal Shrewsbury Hospital and issued requirement notices for breaches of regulations 17 and 18.

Services at the midwife led unit at the Royal Shrewsbury Hospital are currently suspended.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		We carried out an unannounced focused inspection of maternity services in response to concerning information we had received in relation to care of women in this department. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection.

Summary of findings

Contents

The Royal Shrewsbury Hospital

Services we looked at
Maternity

Summary of this inspection

Background to Royal Shrewsbury Hospital

We previously inspected the maternity service at the Royal Shrewsbury Hospital in August 2018. We rated it as inadequate in the safe and well led domains and inadequate overall. Following this inspection, we issued five requirement notices.

Shrewsbury midwife led unit is situated in the grounds of Royal Shrewsbury Hospital. There is two labour rooms and a pool for use in labour or water birth. In addition, there is a four-bed bay. An ante-natal clinic and the community team were based at the unit.

We spoke with the matron, midwives and support staff. We looked at the environment, reviewed records and policies and procedures.

There had been 29 births at Shrewsbury midwife led unit from January to May 2019. Services at the midwife led unit at the Royal Shrewsbury Hospice are currently suspended.

Our inspection team

The team that inspected the service comprised of one CQC inspector and two special advisors with expertise in maternity services.

The inspection was overseen by Victoria Watkins, Head of Hospital Inspection.

Why we carried out this inspection

We carried out an unannounced focused inspection of the maternity service at the Royal Shrewsbury Hospital on 16 April 2019, in response to concerning information we had received in relation to care of women in the department.

How we carried out this inspection

We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

Information about Royal Shrewsbury Hospital

The midwife led unit (MLU) based at the Royal Shrewsbury Hospital provides services 24-hours per day, seven days per week service.

Shrewsbury and Telford Hospital NHS Trust provides maternity services at the Princess Royal Hospital, Telford.

The maternity services available to women include home birth, a midwife led unit (MLU), a consultant-led delivery suite, a range of antenatal clinics including ultrasound scanning and foetal medicine, a day assessment unit, triage, one antenatal ward, two postnatal wards one

Summary of this inspection

located in the consultant led unit and one located in the MLU. Specialist midwives are available to support the women and midwives. Additional antenatal and MLU services are provided at the Royal Shrewsbury Hospital.

The trust also employs community midwives, who provide care for women and their babies both during the antenatal and postnatal period and provide a home birth service. The community midwives are aligned to the local GP practices.

Within the MLU at the Royal Shrewsbury Hospital, there were four post-natal beds on the unit and three delivery rooms. There was a midwife led antenatal clinic and community midwife base at the unit. We did not inspection the antenatal clinic or community midwife team.

During the inspection, we visited the midwife led unit. We spoke with six staff including registered midwives, health care assistants and administrative staff. During our inspection, we reviewed six sets of patient records. Services at the midwife led unit at the Royal Shrewsbury Hospice are currently suspended.

Maternity

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection. We found that:

- Midwife staffing within the maternity service was not adequate. Staff vacancy deficit in March 2019 was reported as 11% (22 whole time equivalent (WTE)). This rose to 26% (50 WTE) when the identified Birthrate Plus requirements were included. The Birthrate Plus workforce planning system provides each maternity service with a detailed breakdown of the number of midwives required for each area of service in both hospital and community.
- 28 midwives had been interviewed following approval of Birthrate Plus workforce planning. The recruitment process would take months to establish a full workforce with appropriate skills and experience.
- Midwife sickness rates on the unit were high. Rates were 8.7% qualified staff and 10.3% for unqualified staff.
- The birthing room was very small and would require some adjustment if emergency access and equipment was required. The birthing pool room was not suitable for use, unless it was appropriately staffed. Staff told us the birthing pool was not used because they could not guarantee there was enough staff.
- Tools used to monitor deterioration were not in line with up to date national guidance.
- Managers did not always provide appropriate oversight, leadership or support to staff on the unit. Clinical staff often worked over and above their normal working hours to ensure appropriate staffing levels and local management of the unit was met.

However:

- Clinical staff were committed to providing a good quality service to people who used the unit.
- Patient records were recorded accurately and contained all the right information to inform safe, person centred care.
- Clinical staff supported each other and worked with involved professionals to ensure all patient's needs were met.
- Cardiotocography (CTG) monitoring and review was only completed on the consultant led unit at the Princess Royal Hospital in Telford. Its purpose was to monitor foetal well-being and allow early detection of foetal distress. This meant that women from Shrewsbury would have to travel to Telford for CTG monitoring.
- Equipment was in good working order and a new track and trace electronic system had been introduced.
- Incident reporting had increased to demonstrate openness to improve from lessons learnt.
- Midwives told us the daily safety huddles that had been introduced were a positive initiative to help with planning and managing the service and women safely.
- Matrons had improved access to the board via the chair through maternity oversight committee board involvement.
- Staff told us the preceptorship model was well supported, encouraging retention of new staff.
- Staff were allocated personal mobiles with applications to improve access to patient information in a flexible way.

Maternity

Are maternity services safe?

Environment and equipment

The service had suitable equipment which was ready for use, however it was not always easily accessible. For example, the resuscitaire was kept in the corridor and based on which room was used, furniture would have to move to accommodate it.

- The environment of the midwife led unit had improved. The environment during our previous inspection was unfit for purpose. This was because it was a temporary environment which was cramped with five services working alongside each other within a small area. This posed a fire risk and infection control issues. Since our previous inspection, the midwife led unit had been renovated which increased the space. Environmental risk assessments had also been carried out. We reviewed individual environmental risk assessments, including the manual handling and evacuation for women who used the birthing pool room. Each risk assessment highlighted control measures and actions needed to ensure safety. Staff told us the facilities and premises to keep people safe had improved.
- The MLU had three delivery rooms with appropriate equipment, but women could not always use them safely. One was a birthing pool room, with a bath. The room had evacuation equipment; however, four members of staff would be required to assist an evacuation in the birthing room and staff might not always available in those numbers. This meant the option of the pool room was not always be available. We also saw the bath was dusty and needed to be cleaned.
- The birthing room with a bed presented some safety risks.There was a bed, chair, and wash facilities with little room to accommodate staff or visitors.If the resuscitaire was required in the room, the bed would have to be moved to make room for it.Staff told us there had been no incidents or issues relating to the use of this room.
- An additional birthing room was available, with an adaptable birthing couch.This meant there was space for movement and flexibility. However, all of the birthing rooms were clinical and functional, rather than comfortable and relaxing.

Assessing and responding to patient risk

Risks to women were assessed and their safety monitored and managed, so they were supported to stay safe. However, staff did not always use the most up to date tools and guidance.

- Staff attended daily handovers and planned shift changes to ensure women's care was discussed and managed in a safe way, with multi-disciplinary involvement. The safeguarding midwife attended the daily huddle to support staff in managing safeguarding concerns. The daily huddle information was recorded so staff, who could not attend, were kept up to date with information relating to women.Staff told us the huddles were meaningful and helped keep people safe.
- Staff completed comprehensive risk assessments for people who used services and risk management plans were developed in line with national guidance. We looked at six patient care records and each had a comprehensive risk assessment with reviews at each documented contact.Where additional complexities were identified, information outlining discussions with other professionals, to help review and manage risk, was recorded well. For example, women with mental health diagnoses were jointly reviewed with mental health professionals.
- Staff identified and responded to changing risks to women, including deteriorating health and wellbeing and medical emergencies. The Modified Early Obstetric Warning Score (MEOWS) was used and we saw this recorded in women's notes. This was a tool to aid early recognition of acutely unwell women. Audits were undertaken to ensure staff compliance and evaluate performance. Each woman's MEOWS score was recorded on admission to triage and attendance at the midwife led unit or assessment unit**.** Midwives and medical staff used their clinical judgement in each individual case, following the national guidelines for

frequency of repeat observations. For example, a woman after caesarean section, being transferred to the post-natal ward, would have observations recorded at least four hourly, for 12 hours.

- Women seen in the community had a set of MEOWS observations calculated on maternal post-natal notes at each visit. Their observations were compared with a laminated standard MEOWS chart to check whether they required action or escalation.
  - Staff followed the escalation policy on women who deteriorated. This was tested through skills and drills scenario training. Women who received a medical escalation were appropriately reviewed by a doctor. Audited results in April 2019 showed compliance was between 100% and 96%.
  - Staff identified and responded to changing risks to women and babies using recognised tools. Staff used neonatal early warning scores (Neo-NEWS) for assessing babies and maternal early warning scores (MEWS) for mothers to observe and review their wellbeing.
  - Midwives were trained to complete NIPE), new-born baby checks, within 72 hours of birth. Their skills were kept up to date and observed by managers. For example, obstetric skills were carried out and observed weekly by the manager to ensure competency.
  - Risks to women were assessed and their safety monitored and managed. In response to previous inspections, cardiotocography machines, used to record the fetal heartbeat during pregnancy, had been removed from the midwife led unit. All monitoring was carried out in the triage area at The Princess Royal Hospital. This process ensured early escalation of risk was identified and reviewed by senior midwives and medical staff.
  - Reduced fetal monitoring guidelines had been reviewed and women were advised to attend the consultant unit triage for review by a midwife and on-site medical staff.
  - Midwives identified and responded appropriately to changing risks to women who used services, including emergencies, seeking support from senior staff and medical staff. We saw incident reviews had taken place which had identified timely escalation had occurred. Reviews also identified learning points which were shared at a three-minute brief during handovers.
  - Risk assessments were carried out on women admitted to the service. For example, each woman had a venous thromboembolism (VTE) assessment completed on initial booking and reviewed again at 36 weeks. arly warning score charts, sepsis screening tools, waterlow, pressure ulcer top to toe risks assessments completed and any identified risks were managed appropriately.
  - Consultants were notified of any potential complications and when assessed as appropriate, they attended the unit for difficult deliveries. This meant women were safely managed by staff with the right level of skills. Staff could seek support from senior staff in these situations. Staff informed the delivery suite (midwife to midwife) at the main hospital, in advance and had plans in the event there were medical emergencies.
  - The service had agreements with other local specialist hospitals with the resources needed to continue to care for women with specialist needs. Processes were in place to ensure a smooth transfer across to other specialist hospitals. Support was in place at both ends of the process. We saw an example of a neonatal transfer to a specialist acute hospital appropriately and effectively completed.
  - There were local agreements with ambulance services on attendance at emergencies or when transfer was required. Staff told us that there had been no incidents relating to use of ambulance services.We saw no recorded incidents relating to local use of ambulance services. led units
  - Women who required critical care could be escalated and transferred in a timely manner to ensure safe management. Liaison with critical care was available in the event of a woman who required the transfer, or input from critical care services could be accessed immediately.

Midwifery Staffing

Maternity

The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Midwife staffing of the maternity service was not adequate. The staff vacancy deficit in March 2019 was reported as 11% (22 whole time equivalent (WTE)). This rose to 26% (50 WTE) when the identified Birthrate Plus requirements were included. The Birthrate Plus workforce planning system provided each maternity service with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. Vacancy rates were 11-14 whole time equivalent staff.
- Matrons across maternity services worked together to review staffing for the midwife led unit monthly. We reviewed staffing reports for the midwife led unit (MLU) from September 2018 to April 2019.Each report highlighted where staffing deficits were service wide. This meant we did not have a breakdown of vacancies specifically for the Royal Shrewsbury Hospital MLU. The March 2019 report documented the closure of the MLU was due to staffing issues. Each report recorded efforts made to recruit to outstanding posts. For example, by March 2019 there had been 28 band five midwives interviewed. This demonstrated plans were underway to fill the vacancies.
- Planned and actual staffing levels and skill mix was two midwives and one midwife support worker on a day shift and one midwife and one support worker on a night shift.Managers told us shortfalls of trained staff, due to sickness and other absences, during the day were managed with community staff support and additional support staff. The contingency plan for staffing was that staff who had worked their hours could be asked to stay later and work additional hours.
- Agency staff had not been used within the MLU but bank work was allocated to ensure staffing levels were met. This had been explored and documented in staffing review meetings as an option to cover staffing shortfalls caused by sickness or uncovered maternity leave. Matrons recorded in the staffing report that for both trained and untrained staff shortfalls had been covered by existing staff. There was recognition by matrons this had become increasingly difficult because of staff morale. Midwives attending for bank shifts told us this impacted on their wellbeing and often resulted in sickness.
- An on-call midwife was available for a night time delivery. There were two midwives on call at night for each midwife led unit, at the Royal Shrewsbury Hospital and The Princess Royal Hospital. However, the on-call midwife would have to provide cover for the MLU and the consultant led unit at The Princess Royal Hospital. Staff told us they did not always have enough staff to cover on-call night time deliveries. This would mean staff would have to work additional hours to cover this.
- Staff told us there was no designated deputy in the absence of the ward manager. The ward manager had been on leave for three weeks at the time when we were on inspection. This meant that there was no contingency leadership on site for those three weeks.
- Sickness rates for the service had not improved since the last inspection. These were monitored, but no immediate action had been taken. Sickness rates were 8.7% for qualified staff and 10.3% for unqualified staff. We were told this would further add to the staffing deficit and have an impact on those staff who remained.
- Women who required a transfer to the consultant led unit during emergency situations left the unit with one midwife less than the planned numbers. One midwife with the support of a porter, transferred the woman to the unit following a midwife to midwife handover.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. We saw this in the six patient records we reviewed.
- People's individual care records, including clinical data was written and managed in a way that kept people safe. All the six patient records we reviewed were completed accurately and contained all relevant information to keep people safe. Each record had a

schedule of antenatal care visits documented. Consent forms were completed, for example, for vitamin K injections. Risk throughout pregnancy was documented for each visit. When complex needs were identified, we saw reference to those needs recorded at each visit. We also saw triage appointments were well documented.

- Antenatal reduced foetal movements were clearly documented. Further care plans were completed, clear and appropriately signed by a midwife and registrar.Antenatal growth charts were well populated.
- Staff ensured there was a second signature to review documentation in all care records. For example, all partograms were well completed. A partogram or partograph is a composite graphical record of key data (maternal and foetal) during labour entered against time on a single sheet of paper.
- Not all staff had access to necessary equipment for reviewing patient records. Staff were expecting to be provided with mobile phones, with applications that allowed them to access patient information needed to deliver safe care and treatment. For example, care and risk assessments, care plans and case notes.Staff we spoke with told us not all staff had access to the new technology which meant they could not access patient records in an accessible and timely way.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women's honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The service managed the investigation into patient safety incidents well, but staff told us they did not always receive feedback. We found that feedback following incidents was not consistently provided to all staff.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave women honest information and suitable support.
- Staff told us they were invited to serious incident meetings; however, they did not often attend due to staffing.

Maternity Dashboard

The performance was monitored over time by the trust and measured against national rates on a monthly maternity dashboard. Safety was monitored using information from a range of sources including case note review, clinical incident review and monitoring of triage.

- The service had achieved results which were better than the national average. Skin to skin within one hour of birth was recorded as 99% which was better that than national average of 80%.

Are maternity services effective?

We did not inspect against this key question.

Are maternity services caring?

We did not inspect against this key question.

Are maternity services responsive?

We did not inspect against this key question.

Are maternity services well-led?

Leadership

The service had a ward manager based onsite with the right skills and abilities to run a service. However, staff told us that the matron was not always accessible.

- The matron was not always visible or accessible. The matron was not based at the midwife led unit (MLU). We were told by staff the ward manager was visible

and approachable and a good source of support and provided updates. Staff told us they were unlikely to receive updates when the ward manager was not at work.

- The ward manager had been away for three weeks which meant there was limited oversight of the MLU during this period. There were no formal arrangements to cover this period. This meant staff may not receive all the information needed to support them in their roles. During this period, midwives were also expected to manage staffing daily and cover for shortages even if was outside their normal working hours.

Governance

Leaders did not operate effective governance processes. Staff at all levels did not always have regular opportunities to meet, discuss and learn from the performance of the service.

- Improvement plans had been implemented by the management team but not all had been fully embedded. For example, mobile phones to allow flexibility of access to patient information, as well as for use as a lone working device, had not been fully implemented. Equipment to standardise community bags was still a work in progress.
- Safe midwifery staffing levels remained under review. There was no clear staffing plan for the midwife led unit (MLU) or the maternity service. The business case to recruit to Birthrate Plus had been agreed but not implemented. This meant staffing levels would continue to be an issue. A recruitment plan and contingencies were in place but improvements to staffing were not likely to be seen for at least six months.
- The matron had access to the chair and to the board via meetings, emails and telephone conversations and had reported this as positive. The relationship meant there was an effective flow of information and improved communication to the board relating to maternity matters.
- Leadership staff attended a weekly obstetric risk meeting which included a consultant level review of clinical incidents. The review looked at the initial contact with the women for their current pregnancy up to the point of a reported incident. The meeting was documented, and an associated action plan was produced to keep up to date with actions and improvements made. The information from the meeting was shared with clinical staff on the unit at the morning safety huddles if a representative attended.
- Leadership staff were engaged in monitoring data and audits to provide assurance that an effective clinical management system was in place. We saw this documented in meetings minutes and was told during discussions with staff. This meant there was a system to escalate women appropriately for medical support and review in line with national clinical guidelines.
- All policies National Institute of Health and Care Excellence (NICE) operational policies and guidelines were reviewed and in date. They had associated standard operating procedures attached and staff knew where to access them.

Managing risk and performance

Systems for identifying and managing risks had been put in place. Risks, issues and mitigating actions were recorded on the risk register. Staffing vacancies and staff sickness remained a risk to meet the needs of the women who used the unit.

- Staff managed risk by completing clinical incident reports which were forwarded to the obstetric risk group. A monitoring report was produced on a weekly basis. Staff reported on outcomes of audits, for example The audits were completed to evaluate performance.
- Potential risks were considered when planning services, however we heard that staff 'good will' maintained staffing levels and covered sickness and vacancies. The service had interviewed 28 band five midwives following approval of Birthrate Plus workforce planning. It would take many months to establish a full workforce with appropriate skills and experience. Bank staff were used to cover in the interim. Staff told us this had an impact on their wellbeing.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure midwife staffing is improved to ensure women receive safe and high-quality treatment.
- The trust must ensure all risks are assessed, managed and mitigated through good governance systems and in line with up to date guidance.

Action the provider SHOULD take to improve

- The trust should ensure the birthing room is adequately staffed and has timely access to the right equipment to ensure women had the choice to use the rooms safely.
- The trust should ensure staff receive appropriate leadership to support them in running a safe and effective service to people who chose the unit for their needs.
- The trust should ensure staff have access to mobile phones to allow flexibility of access to patient information as well as for use as a lone working device to keep them safe.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance