University Hospitals Sussex NHS Foundation Trust

Princess Royal Hospital

Inspection report

Lewes Road
Haywards Heath
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Date of inspection visit: 26 and 27 April 2022
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Princess Royal Hospital

Inspected but not rated

We carried out this unannounced focused follow up safety inspection of maternity services provided at the Princess Royal Hospital on 26 April 2022 because at our last inspection in October 2021 we found the following concerns:

- The service did not have enough staff to care for women and keep them safe
- Compliance with skills drills and Cardiotocography CTG training was poor with only 60% and 50% of staff respectively having completed their training.
- There was not a systematic approach to prioritising women who attended triage, and staffing levels in triage were not robust.
- Resuscitaire checks were not always recorded.
- Staff did not complete carbon monoxide screening.
- Not all incident investigation reports recorded the learning outcomes or whether feedback had been given to the reporter.
- Not all risks were identified on the risk register.
- The leadership above matron level was not visible.
- Staff morale was low and the workforce was exhausted.

As a result, we issued a warning notice to make sure the trust made improvements. We carried out this return inspection to review compliance to the warning notice issued on the maternity services.

This inspection has not changed the ratings of the location overall and our rating of maternity services remains the same.

Maternity (inpatient services)

Inspected but not rated

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities in maternity services. This inspection did not include all our key lines of enquiry (KLOEs). We looked at KLOEs specific to the warning notice in the domains: safe, and well-led.

We visited the clinical areas of Bolney ward (antenatal and postnatal), central delivery suite, and maternity day assessment unit.

We spoke to staff to better understand what it was like working in the service including senior leaders, midwifes, obstetric staff, nursery nurses and maternity care assistants.

We reviewed four sets of maternity records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made improvements to make sure all staff completed it.

At our previous inspection in October 2021, we found not all staff had completed their mandatory training and training data could not be broken down to site level. At re-inspection, data was provided at site level and we saw that mandatory training figures had improved, with clinical staff including midwifes, nursery nurses and maternity care workers training compliance at 94%. Staff told us that there had been incentives for them to complete their training online, and that they could claim back time for any training done outside of work hours.

At our previous inspection, low levels of staff had completed skills drills training (practical training that all members of the team completed together) and a lot had been delivered virtually online. At re-inspection, skills drills training compliance had also improved with midwifery staff achieving 93% compliance, and medical staff at 83% compliance. We were given context by the trust that the medical staff had been due to attend a session on the 26th April but due to operational pressures had not been able to. The trust told us that this figure should be over 90% by the end of May 2022. Staff confirmed that they had attended skills drill training and found it useful.

Environment and equipment

Maternity (inpatient services)

The design, maintenance and use of facilities, premises and equipment kept people safe. However, managers did not always monitor equipment checks.

During our last inspection we had identified gaps in checks of emergency equipment and told the trust they must make improvements.

During re-inspection was saw that there were still some gaps in the daily safety checks of specialist equipment. Checks on crash trolleys should be completed daily, but we saw several gaps on the checklists and on one of the crash trolleys on Bolney ward, we observed that the paediatric defibrillator pads had passed their expiry date in 2021. There was a hand-written note on the pads advising that replacements had been ordered in April, however this had not been followed up two weeks later. A staff member told us that there were in-date pads within the locked section of the trolley, however there was nothing to alert other staff that they were there. We escalated this to a manager who advised us they would get some replacement pads from another department.

The unit did not have a resuscitaire in every labour room, when we raised this with managers, we were told this had been risk assessed and a business plan had been submitted to purchase more. However, this was not on the risk register.

Assessing and responding to patient risk

Staff identified and quickly acted upon women at risk of deterioration. However, staff did not use a nationally recognised tool to prioritise care for women attending triage.

During the last inspection we found that staff did not use a nationally recognised tool to triage women at risk of deterioration. At re-inspection, we found that the service had implemented the Birmingham Symptom Specific Obstetric Triage System (BSSOTS) tool in triage, however this was not fully embedded at the time of our inspection, and two of the four patient records we reviewed had not been Red Amber Green (RAG) rated to identify those most at risk. Managers told us that the system was in its infancy with processes not fully in place yet and acknowledged that it was a “work in progress”. Managers had begun auditing use of the BSSOTS tool to ensure practice was embedding. One of the measures audited was whether a woman was seen within the timeframe needed according to the risk of concern. We were provided with five weeks of data from the 21 March to 24 April. Data showed that from the 4th April 2022, all women were seen within the target timeframe. However for the week commencing 21 March, only 78% of women were, due to awaiting medical review or bed transfer. On one week, no audit was completed. During the last inspection we found that the service had one midwife who was responsible for both managing telephone and face to face triage on any given shift. This meant that if they were caring for a woman face to face there was a potential delay in answering the phone and vice versa. At re-inspection there was still only one midwife assigned to triage, and therefore this risk remained the same. We reviewed staffing data from 28 March 2022 – 28 April 2022 and saw that out of a possible 32 day period, there was only a dedicated triage midwife for 20 of those days (66%). The mitigation for this was to transfer all triage line calls to the central delivery suite.

At our previous inspection, we identified that staff did not record carbon monoxide screening, which was part of ‘saving babies lives 2016’ initiative. At re-inspection, we found that although staff asked patients about their smoking history, they still did not perform carbon monoxide screening on the four records we reviewed. This meant that staff could not be assured that women had safe levels of exposure during their pregnancy.

Midwifery staffing

Maternity (inpatient services)

The service still did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, levels of sickness and staff turnover remained low. The trust had commissioned a staffing review..

At out last inspection we found that there was a lack of suitably trained midwives to deliver safe care and treatment. Because of this we asked the trust to review staffing and implement strategies to increase midwifery staffing across the unit. Managers told us they had recruited one band 5 midwife and two band 6 midwives since our last inspection, but this was across both the Royal Sussex County site, and the Princess Royal site. The trust had also commissioned a Birth-rate plus staffing review which had highlighted gaps in staffing and this review helped the trust make improvements.

During re-inspection, staff told us that staffing was still pressured and we observed that staff did not always get a break. Staff told us that sometimes they did not feel able to provide women the level of care they would like to do and that this was “heart-breaking”. We reviewed the rotas for the week leading up to our inspection and saw that staffing was below planned levels on eight out of the nine days. Following the inspection the trust sent us details of their staffing levels for the past 6 months. We reviewed the data for March 2022, and saw that staffing was below planned levels on all but two days. Managers told us that they managed staffing levels daily via a twice daily staffing huddle held virtually. The service had a reducing vacancy rate. At our previous inspection we were told that there was a vacancy rate of 10% for midwifery staff. At re-inspection, data between October 2021 and March 2022 showed that the vacancy rate was on average 4%.

The service had a reducing turnover rate. During our previous inspection the turnover rate had reduced to 9% by August 2021. At re-inspection, we saw that this had reduced further to 0.8%.

The service had consistently low sickness rates. During our previous inspection sickness rates (which were not broken down by staff group) varied between 3 and 5% per month. At re-inspection, the rates remained consistent at around 5%.

Incidents

The service had made some improvements to the incident management process. The service had significantly reduced the backlog if incidents awaiting investigation. Staff recognised and reported some incidents and near misses, however did not always report recurring incidents such as staffing incidents. Managers investigated incidents and fed back to individuals.

At our last inspection, staff told us that they knew what incidents to report and how to report them. However, some recurring incidents such as safe staffing levels, were not always incident reported because staff said it had begun to feel like the ‘norm’. At re-inspection, staff told us that they did report incidents, but sometimes did not add their contact details to the incident as they knew the feedback would be the same or not helpful.

At our last inspection, there had been a large number of open incidents awaiting investigation. At re-inspection, managers told us that this had reduced significantly. Data showed that the service had no ‘near miss’ and ‘no harm’ incidents awaiting investigation for over 20 days. Two moderate/severe harm incidents had been waiting for investigation for over 20 days. This was an improvement since the last inspection.

The service had no never events on any wards. In the 12 months before the inspection the service had not reported a never event.

Maternity (inpatient services)

Is the service effective?

Inspected but not rated

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

At our previous inspection in October 2021, we found not all staff had completed their cardiotocography CTG (electronic monitoring of baby's heart rate) training. At re-inspection, data showed that most staff had now completed their CTG training. The trust training target is 90%. Records from the service (and the Royal Sussex County Hospital site), showed that 92% of midwives had completed their CTG training, and 86% of medical staff. We were given context by the trust that the medical staff had been due to attend a session on the 26th April but due to operational pressures had not been able to.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the necessary experience and capacity to lead effectively and abilities to run the service. They managed the priorities and issues the service faced. They were visible and approachable.

Maternity was part of the Women and Children's Division which covered the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. At our last inspection, the Director of midwifery post was vacant. Since the previous inspection a director of midwifery had been recruited. They had recently joined the trust and had a leadership responsibility for the Royal Sussex County Hospital and Princess Royal Hospital.

The Children and Women's East Divisional Board met monthly. We reviewed the minutes of the meetings held between June and September 2021. Records showed the meeting ran to a standard agenda but did not record attendance.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and although they had regular opportunities to meet, discuss and learn from the performance of the service, due to operational pressures they were not always able to attend these meetings.

Maternity (inpatient services)

At our last inspection, we identified that lessons learned were not always shared with the wider team or service. At this inspection, we found that some improvements had been made. We saw learning from incidents shared in the staff room in a Situation Background Assessment Recommendation (SBAR) format which condensed the learning into an easy to read format. Staff told us that they had an open invite to listen into incident meetings for the service but that they were rarely able to attend due to operational pressures.

Since our last inspection, the service had begun to implement the Patient First methodology, which had been successfully used in other departments throughout the trust. We saw that an improvement board and huddle had been set up, and staff told us they thought these were positive changes to help improve the service.

Management of risk, issues and performance

Leaders and teams did not always use systems accurately to manage performance effectively. They did not identify or escalate all relevant risks and issues to take action to reduce their impact in a timely way.

The service had a women's and children division specific risk register. The risk register included a description of each risk, controls in place, and a summary of actions taken. The initial and current risk rating was included and also any updates since the previous review.

At our previous inspection we found that a risk described to us was not seen on the risk register. At this inspection, a risk regarding not having a resuscitaire in each room was discussed with the senior management team, and we were told that mitigations were in place, however there was no risk matching this description seen on the risk register.

During the re-inspection we spoke with senior managers who correctly identified the top three risks on the risk register for the Princess Royal and Royal Sussex County sites. The top three risks were staffing, inability to provide continuity of care in line with national guidance, and the controlling of high temperatures within the labour ward at the Royal Sussex County site.

The trust continued to engage with the Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. Data provided to us showed that there had been six referrals to the HSIB in the six months prior to our re-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

The trust must improve staffing levels to maintain safe staffing levels. (Regulation 18 (1))

Action the trust SHOULD take to improve:

The trust should ensure the implementation of a systematic approach for risk assessing women in triage is continued to be embedded.

Maternity (inpatient services)

The trust should ensure that regular checks on lifesaving equipment are undertaken.

The trust should ensure that carbon monoxide screening is undertaken.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

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