The Princess Royal 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

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 maternity service, including the Wrekin midwife led unit (MLU) at Princess Royal Hospital on 15 April 2019, to review the assurances we had received relating to conditions imposed on the trusts' registration following the 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 fetal 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 the deputy head of midwifery and other members of the maternity team whilst on site. The assurances were reviewed and seen to be in place relating to effective and continued clinical management for low and high-risk women who present to the midwifery services in line with national clinical guidelines. A clear escalation plan had been embedded to secure timely review from medical staff when necessary.

During our inspection we found improvements in practice. Examples include but are not limited to Cardiotocography (CTG), Modified Early Obstetric Warning System (MEOWS) and the implementation of reduced fetal movement and triage guidelines. The MEOWS observation chart facilitates a standardised approach to recording women's vital signs to alert the clinical team to any clinical deterioration. The MEOWS score determines the urgency and scale of the clinical response. This guideline provides guidance for staff within the maternity services on recognising and monitoring the obstetric patient using MEOWS. This enables early recognition of deterioration, advice on the level of monitoring required, promote better communication with the multi-disciplinary team and ensure prompt management of any woman who is deteriorating.

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

Action the trust SHOULD take to improve**:**

- The trust should ensure a review of the staffing at the midwife led unit is undertaken as part of the Better Births programme.

Summary of findings

- The trust should ensure the environment in the MLU is safe by keeping harmful chemicals secure.
- The trust should ensure all medical staff are appropriately trained in cardiotocography analysis.
- The trust should ensure clinical specimens are handled and managed in line with policy.
- The trust should ensure all actions are taken to ensure governance arrangements are effective.

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 did not rate this service at this inspection. We did not inspect any other core service or wards at this hospital. We did not cover all key lines of enquiry.

Summary of findings

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Services we looked at
Maternity

Summary of this inspection

Background to The Princess Royal Hospital

We carried out an unannounced focused inspection of the maternity service, including The Wrekin midwife led unit (MLU) at The Princess Royal Hospital, on 15 April 2019, to review the assurances we had received relating to the Regulation 31 report submission.

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.

We previously inspected the maternity service at the Royal Shrewsbury Hospital in August 2018. We rated it as requires improvement overall. Following this inspection, we issued a requirement notice relating to the need for appropriate clinical management of low and high-risk women.

The Princess Royal Hospital has 23 maternity beds and 17 antenatal beds, five of which are used for day assessment and triage. There are 13 birthing rooms on the delivery suite. The Wrekin midwife led unit (MLU) has 13 postnatal beds and four birthing rooms.

The overall trust total of births for January 2019 was 346 compared to the local target of 375 to 425.

Our inspection team

The team that inspected the service comprised of a 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, including The Wrekin midwife led unit (MLU) at The Princess Royal Hospital, on 15 April 2019, to review the assurances we had received relating to the Regulation 31 report submission.

How we carried out this inspection

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Information about The Princess Royal 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

Summary of this inspection

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 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	
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.
- Midwife sickness rates were high.
- Clinical specimens were not handled in a way which promoted infection prevention and control practices.
- Medical staff cardiotocography (CTG) training analysis was yet to be completed.
- Staffing vacancies and staff sickness remain of concern to maintain a safe and appropriate workforce to meet the needs of the women. Birth rate plus had just been agreed with approval to recruit 29 midwives to meet their requirements. These developments would impact positively on the quality and sustainability of the service; however, it will take many months to establish a full workforce with appropriate skills and experience.

However:

- Cardiotocography monitoring and review was now only completed on the consultant led unit only.
- 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.
- Medical handover now occurred twice daily on the labour ward.
- Midwives spoke positively about the changes made to provide a safer service.
- Midwives told us the increased visibility and approachability of the senior managers, matrons and deputy head of midwifery has raised morale and the culture felt more engaged and open.
- They explained how the preceptorship model was well supported, encouraging retention of new staff.
- Appraisals were completed effectively to discuss individual feedback. Great respect was shown from managers and currently appraisal completion was 82%. Staff told us they were encouraged to speak with the co-ordinator at all times.
- CTG centralised monitoring was in place on labour ward for full oversight and fresh eyes.
- The daily management huddle ensured that each area had an oversight of risk and activity, enabling support and advice to be given.
- Improvements to the service had been signed off by senior leaders. Improvements included; handovers being completed twice daily on labour ward, high risk women in labour were reviewed by medical staff and reduced fetal movements policy had been reviewed with a defined pathway developed.
- Weekly and monthly reviews of the CQC submission and quality improvement plan had focused the service to embed the changes and ensure timely progress.

Maternity

Are maternity services safe?

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- A computerised system for monitoring Cardiotocography (CTG) traces had been implemented which gave doctors a centralised view across the whole maternity ward. All CTG traces could be monitored from the doctor's office.
- The service had suitable equipment which was easy to access and ready for use. On the postnatal ward we saw discharge packs had been pre-prepared to support timely discharge for women and their babies.
- Maintenance of equipment had improved since the last inspection. The service had introduced a new electronic reporting system to track and trace repairs of equipment.
- Storerooms on the wards were locked and accessible by key code entry or keys. The rooms had been re-organised to ensure safe storage and reduce over stocking. However, On the MLU we found the storeroom and cleaning cupboard unlocked. This was a safety risk as harmful liquids and equipment were stored there. We also found a sluice room door which was held open by a waste bin. This was raised with staff, following which, the doors were closed and assurances were given that those which required locking would remain locked.
- Safety and safeguarding systems, processes and practices were communicated to staff. This was achieved through the daily three-minute brief, discussion during handovers and safety huddles. This included when updated policies were available on the intranet
- The main ward facilities and premises were seen to be in order. Wards, seating areas and the midwife led unit (MLU) were visibly clean and accessible.
- The management of waste was appropriate. However, clinical specimens were not always handled in line with the trust's policy. For example, urine samples were being tested on an emergency trolley in the triage arear and blood samples at women's bedside on the delivery suite were not labelled.

Assessing and responding to patient risk

Risks to patients were assessed and their safety monitored and managed, so they were supported to stay safe.

- Processes ensured early escalation of risk was identified and reviewed by senior midwives and medical staff. For example, cardiotocography (CTG) machines, used to record the fetal heartbeat during pregnancy, had been removed from the midwife led unit (MLU) and all monitoring was carried out in the triage area at The Princess Royal Hospital.
- Maternal pulse and fetal heartbeat were appropriately monitored. Midwives followed the gold standard procedures for differentiating maternal pulse from fetal heart including the use of pinnards and using manual palpation of maternal pulse and/or a Spo2 pulse monitor.
- Appropriate action was taken when CTG traces were suspicious or unreadable. When a trace was classed as suspicious or pathological the correct steps were taken with escalation to the senior obstetrician (registrar or above) and discussed with the senior midwifery leader on shift and a plan of care made. If difficulties were faced when interpreting or reading a CTG, ultrasonic (USS) transducers and fetal scalp electrodes were used. This was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- Records relating to CTG traces were complete. We reviewed seven sets of women's care records on the delivery suite. All CTG traces seen stated the reason for monitoring and were evidence based. All notes reviewed included a date, hospital number, women's name, gestation and time of trace prior to commencement.
- Relevant guidelines had been updated and were available to staff. Upon review of the service's triage guidelines we saw they were in line with national guidance and included a clear escalation plan. Reduced fetal monitoring guidelines had been reviewed and women were now advised to attend triage on the consultant led unit, for review by a midwife and on-site medical staff. The guidelines had been in place since October 2018.
- Relevant processes and documents had been updated to ensure safe practice. For example, a new proforma and obstetric handover process had been implemented. Reviews of management plans for all high-risk women had also been initiated. The improvements had been made in October 2018.

Maternity

- Triage escalation sheets had been introduced to evidence appropriate escalation. Triage escalation sheets were reviewed by the service and we saw they had achieved a 97% completion rate. This demonstrated care and management in triage was appropriate.
- Assessment cards were used within triage to record and monitor women's care. They were called triage assessment cards (TAC) and they were used as a proforma. The TAC was completed by midwives and doctors to document the management of women's journey through triage. Different TACs were used depending on the presenting situation, for example, reduced fetal movements or prolonged rupture of membranes.
- Each proforma contained standard pages which promoted consistency. For example, observations and each TAC were aligned to relevant guidelines. Midwives were able to fully assess the women based on their presenting situation, medical and obstetric history. The form was a continuous document and captured doctors' review if escalation was determined either by the woman's assessment or guidelines. The TAC was retained in the woman's handheld antenatal record until delivery, at which point the paperwork was filed in hospital maternity records.
- The first two TACs had been included to give an indication of the patient journey through triage, demonstrating appropriate management of individual cases. A monthly summary of the 20 TACs were provided following month end.
- Risks to women were assessed appropriately. Comprehensive risk assessments were carried out for women and pathways were managed positively. Initial assessments were recorded as red, amber, and green to identify risks and plan a suitable pathway.
- Midwives raised no issues regarding delays with baby checks. The service was able to ensure there were appropriate numbers of Newborn and Infant Physical Examination trained staff available to carry out the checks.
- Midwives identified and responded appropriately to changing risks to people who use services, including emergencies, seeking support from senior staff and medical staff. Modified Early Obstetric Warning Scores (MEOWS) were used. We saw they were recorded with appropriate auditing to ensure compliance. Each woman's MEOWS score was recorded on admission to triage, attendance at the midwife led unit or assessment unit**.** Midwives and medical staff used their clinical judgement in each individual case following national guideline 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.
- Whilst seen in the community, women 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.
- The service had an escalation policy for when women deteriorated which staff complied with. Compliance with the escalation policy was tested through skills and drills scenario training. Medical escalation appropriately reviewed by a doctor was recorded as between 100% and 96% during April 2019.
- Neonatal early warning scores (Neonatal NEWS) were recorded on babies in the post-natal ward.
- There were 78 hospital and community midwives trained to complete new-born and infant physical examination (NIPE), new-born baby checks within 72 hours of birth.
- Consultants were notified of any potential complications and attended the unit for difficult deliveries.
- Service level agreements were agreed with local specialist centres. Processes to ensure a smooth transfer were implemented and were supported at the sending and receiving sites. During our inspection, we observed the process when another acute NHS trust hospital received a neonatal transfer safely and appropriately from the service.
- Ambulances from the local NHS ambulance service would be called to midwife led unit when a transfer was required.
- Liaison with critical care took place in the event of a woman requiring transfer or input from critical care services.
- Shared understanding and learning were promoted during the weekly obstetric risk meeting. This included a consultant review of clinical instances, from the initial contact to the point of the reported incident. We reviewed incident reports and saw timely escalation had occurred and learning points had been identified. Any learning was discussed at the three-minute brief, during handover.

- Consultants attended the twice daily ward handover and high-risk women were reviewed twice daily. The anaesthetist also attended the handover.
- Weekly obstetric risk /consultant clinical incident review meetings took place. An action plan was monitored and signed off as learning had been embedded.

Midwifery Staffing

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.

- Staffing levels and skill mix were planned and reviewed with monthly staffing data reports raised with the executives and submitted to trust board.
- Actual staffing levels and skill mix only met the trust's planned levels using bank staff. The reason for this was due to staff sickness and absence. However, no agency midwives were used within maternity staffing.
- Sickness rates for the service had not improved since the last inspection. These were monitored but no immediate action had been taken. Levels ranged between 7% and 12% on the Wrekin midwife led unit (MLU) and between 4% and 12% on the wards.
- On the Wrekin MLU, we found staffing was set to the minimum requirements. The unit had the potential for four birthing women and 12 inpatients, but the current staffing levels were not adequate to meet the needs of the women at all times when the unit was full.
- 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 Princess Royal Hospital and Royal Shrewsbury 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.
- Scheduled handovers and planned shift changes ensured women's care was discussed and managed in a safe way with multi-disciplinary involvement.
- We were told more rotation into the MLU had occurred in the last six months.
- Midwives wore 'midwife in charge' arm band across all departments within maternity to ensure they were identified.

Records

Staff kept appropriate records of patients' care and treatment. Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- Women's individual care records, including clinical data, was written clearly and concisely and managed in a way that kept them safe.
- All notes trolleys were locked and records were handled confidentially.
- Information needed to support safe care and treatment was available to relevant staff on their internal electronic records system. The records could be accessed in a timely and accessible way along with women's hand-held notes.
- The correct algorithm was followed on each cardiotocography trace to ascertain if it needed to be escalated. All trace interpretations we reviewed were accurate as per NICE (2019) intrapartum guidance.
- Handovers between staff used the technique known as situation, background, assessment, recommendation (SBAR), to facilitate prompt and appropriate communication.
- Arrangements for handovers were safe. To ensure the management of high-risk women was reviewed on the delivery suite a handover took place. We review data which showed compliance was almost 100%. However, there was one instance, during a week in February 2019, when a handover did not take place.
- When women moved between teams, services and organisations all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols. However, triage notes were currently not added to the electronic patient record system but plans were in place to include these.
- The electronic patient records system supported staff to deliver safe care and treatment by managing the information about women who use the services. When problems were identified the system could highlight the name to indicate concerns such as safeguarding.

Incidents

Staff managed patient safety incidents well. Staff now recognised incidents and reported them appropriately. Managers investigated incidents and there was evidence of shared lessons learned. However, we found feedback following incidents was not consistently provided to all staff.

- The midwifery service had strengthened its risk management structure and governance processes. A Royal College of Obstetricians and Gynaecologists review identified the service had strengthened the way they investigated clinical incidents and utilised external investigators.
- The service used a dashboard to monitor safety and quality performance. The maternity quality performance dashboard has been amended to reflect national quality measures.
- Meetings had been implemented to review safety performance. A weekly obstetric risk meeting had been developed to include consultant level review of clinical instances.
- Documents had been implemented to review of patient care. A pilot proforma had been developed to capture a structured review of case notes, including medical review. Re-review included the documented care plan, evidence of appropriate escalation and cardiotocography analysis.
- Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate. Case studies had been introduced to the risk review meetings to share lessons learnt and to witness the impact of incident reporting, on improving safety.
- Safety alerts, recalls and reviews were discussed within the weekly obstetric risk meeting and cascaded through the three-minute brief and intranet.
- Actions were agreed, evidence of learning/improvement was identified, and themes were captured from incidents. The outcomes were cascaded appropriately depending on the findings, for example, at three-minute briefs, safety huddles, changes to wording of guidelines and one to one meetings. These reviews were embedded within the circulated obstetric risk meeting minutes.
- Incident reporting had increased since the last inspection. During 2018, 546 were reported. From January to April 2019, 306 had been reported. Staff told us they were encouraged to report incidents. However, staff also told us they sometimes did not have time to report them.
- Robust arrangements were in place for reviewing and investigating safety and safeguarding incidents. People involved in the incidents were included in reviews and investigations.
- Themes and trends were identified and actions were taken to address them. Themes and trends, included investigation results, were discussed at risk and ward meetings and during three minute briefs.

Maternity Dashboard

The performance of the service was monitored over time. A monthly maternity dashboard was used to measure the service's performance against national rates. This was carried out at trust and service level. Safety was monitored using information from a range of sources including case note reviews, 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 than the national average of 80%.

Are maternity services well-led?

Leadership

The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.

- The care group director and deputy head of midwifery were fully engaged with the care quality commission (CQC) improvement plan and changes in practice to meet CQC requirements. Weekly submissions to CQC showed evidence of positive change being made to improve the safety of the service.
- The management understood the challenges to quality and sustainability and have identified the actions needed to address them in a timely way.
- The deputy head of midwifery, and matrons were visible and we were told they were approachable. The daily management huddle ensured that each area had an oversight of risk and activity, enabling support and advice to be given.
- Priorities for ensuring effective leadership have been identified and a replacement head of midwifery had

recently been secured. Succession planning had improved with new opportunities to develop into specialist roles and progression through preceptorship.

Governance

The service had a systematic approach to continually monitor the quality of its services.

- Improvements had been made to ensure the safety of women using the service was monitored. For example, handovers were being completed twice daily on labour ward, high risk women in labour were reviewed by medical staff and the reduced fetal movements policy had been reviewed and a defined pathway developed.
- Action was being taken to further monitor performance within the service. A triage and Modified Early Obstetric Warning Scores (MEOWS) audit was due to commence in April 2019 which planned to be signed off by maternity governance in June 2019.
- Work was required to ensure governance arrangements were effective. For example, medical staff cardiotocography training analysis was yet to be completed. Additional work was also required to ensure implementation of the recommendations from the Royal College of Obstetricians and Gynaecologists report, Birthrate Plus, consultant anaesthetist recommendations and ensuring alignment with neonatal guidelines.
- Midwifery staffing levels were monitored. During our inspection, safe midwifery staffing levels remained under review and as a result a business case to recruit to Birthrate Plus had been agreed and recruitment was underway. However, this was in the early stages.
- Effective processes and systems of accountability were now in place to support the delivery of the strategy. Weekly and monthly reviews of the care quality commission submission and quality improvement plan had focussed the service to embed the changes and ensure timely progress.
- Staff at all levels were clear about their individual roles, responsibilities and understood their accountability.
- Service improvements were being monitored and encouraged. For example, an NHS maternity improvement director had encouraged improvements and supported promotion of changes in policy and procedures. An NHS Improvement senior clinical leader has provided verbal feedback on 'fresh eyes' peer review.

Managing risk and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

- Risks were identified, and actions taken to mitigate them. For example, Ludlow, Oswestry and Bridgnorth midwife led units were suspended and remained closed to births and inpatients. It was identified they were not staffed appropriately to use.
- Assurance systems and processes were effective. Assurance was gained through audit and risk review meetings. External advice had been sought from other maternity units and comparisons made. An assurance monitoring audit plan has been drawn up to commence March 2019. This included an audit of ante-partum continuous electronic fetal monitoring, medical escalation in triage and reduced fetal movement monitoring.
- Robust arrangements for identifying, recording and managing risks, issues and mitigating actions were recorded on the risk register. Upon review of the risk register, we saw staff vacancies and sickness were still a risk to maintaining a safe and appropriate workforce to meet the needs of the women.
- Potential risks were considered when planning services. However, we heard staff 'good will' maintained staffing levels and covered sickness and vacancies.
- Birth rate plus had just been agreed with approval to recruit 29 midwives to meet their requirements. These developments would impact positively on the quality and sustainability of the service; however, it will take many months to establish a full workforce with appropriate skills and experience.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure a review of the staffing at the midwife led unit is undertaken as part of the Better Births programme.
- The trust should ensure the environment in the MLU is safe by keeping harmful chemicals secure.
- The trust should ensure clinical specimens are handled and managed in line with policy.
- The trust should ensure all actions are taken to ensure governance arrangements are effective.