University Hospitals Sussex NHS Foundation Trust

St Richard's Hospital

Inspection report

St Richards Hospital
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Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive to people's needs?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Our findings

Overall summary of services at St Richard's Hospital

Outstanding ☆ ➔➔

We carried out this unannounced focused safety inspection of maternity services provided by University Hospitals Sussex on the 28 September 2021 because we received information of concern about the safety and quality of the service.

Information of concern had been received from several sources about the maternity services across the trust. This included staff whistleblowing, patient complaints and information from the Nursing and Midwifery Council (NMC).

University Hospitals Sussex provide maternity services at St Richards Hospital, Worthing Hospital, Royal Sussex County Hospital and Princess Royal Hospital. This report focuses on our findings at St Richards Hospital.

We asked the trust to send an anonymous staff survey to give all maternity staff the opportunity to share their experience of working at St Richards Hospital and raise and share concerns in a safe and confidential way. The staff survey for was open to staff from 1 to the 15 September 2021, and at St Richards and there were 44 responses. The anonymous results have been used as evidence to support our report.

This inspection has not changed the ratings of the location overall. However, our rating of maternity services went down. We rated them as requires improvement.

Overall, we rated safe and well-led as requires improvement; we did not have enough evidence to re-rate the effective domain.

University Hospitals Sussex NHS Foundation Trust was formerly called Western Sussex NHS foundation Hospital. It changed its name on 1 April 2021 when it acquired Brighton and Sussex NHS foundation Trust.

The trust has five hospitals – Worthing Hospital, St Richards Hospital, Royal Sussex County Hospital, Princess Royal Hospital and Southlands Hospital – which provide a full range of acute services.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Western Sussex NHS Foundation Trust.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, given we were responding to concerns in the maternity and surgery core services we inspected only those services where we were aware of current risks. We did not rate the hospital overall. In our ratings tables we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

How we carried out the inspection

Our findings

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

We visited clinical areas including the delivery suite, the postnatal and antenatal ward (Tangmere ward), and the co-located midwifery led unit.

We spoke with 26 staff, including service leads, midwives (bands 5-7) obstetric staff, consultant anaesthetist, obstetric theatre staff, maternity care support workers, student midwives and the patient safety lead.

We conducted a survey of maternity staff. We observed the morning multidisciplinary handover on the delivery suite, morning handover on the postnatal and antenatal ward (Tangmere) and the morning safety huddle on the delivery suite.

We reviewed eight sets of maternity records and 10 prescription charts. 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. Before our inspection, we reviewed performance information about this service.

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.

Maternity

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

The service did not have enough staff to care for women and keep them safe.

Staff were not up to date with training in key skills.

The design, maintenance and use of facilities, premises and equipment did not ensure women and their babies were safe.

Staff did not always manage clinical waste well.

Records were not always clear and easily available to all staff providing care.

Staff did not always receive feedback from incidents across the trust.

Leaders had the skills but had to take on additional roles to run the service, which meant there was a gap in the leadership structure.

The interim head of midwifery was visible and approachable in the service for patients and staff. However, the further leadership team could not be identified by many of the midwives and staff.

Leaders did not operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service.

However:

Staff understood how to protect women from abuse. The service controlled infection risk well and managed medicines well.

Midwives and medical staff were focused on the needs of women receiving care, and mostly felt supported at a local level.

The service provided care and treatment based on national guidance and evidence-based practice. Outcomes were not always positive for women but action plans ensured poor outcomes were investigated. Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The service collected reliable data and analysed it.

Maternity

Is the service safe?

Requires Improvement

Requires improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but not all staff were able to complete it.

All midwives and midwife care assistants (MCA) were booked onto mandatory training at the beginning of the year by the practice development midwives and the team administrator. Training was added to staff rotas and they received a notification by email from the maternity practice development team. The week before training was due a reminder was sent out. The practice development team kept and maintained a spreadsheet detailing all staff maternity mandatory training and community skills drills.

Recent staffing levels had meant managers sometimes called staff had been into clinical work during protected training hours. We requested recent mandatory training figures from the trust but did not receive these. A staff newsletter stated staff at the antenatal clinic, community teams and the public health and clinical effectiveness teams, across all sites had achieved over 90% compliance in mandatory training. This included fire safety, infection control, information governance, adult and child safeguarding, health, safety and risk, equality and diversity, basic life support and patient manual handling. Other departments were reported to be between 82 and 87% which was below the trust target of 90%.

In August 2021 only 53% of midwifes had completed specific training on fetal monitoring which was much worse than the trust target of 90%. This training included the key skill of cardiotocography (CTG) interpretation. Cardiotocography is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

Medical staffing had a compliance rate of 87.5% for fetal monitoring training. Although this showed higher compliance was still slightly worse than the trust target of 90%.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff mostly had training on how to recognise and report abuse and they knew how to apply it.

Midwifery and medical staff received training specific for their role on how to recognise and report abuse. Staff understood their responsibilities in relation to reporting safeguarding. There were 34 safeguarding alerts raised in July 2021. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Guidance was readily available and contained contact numbers of the relevant authorities, alongside an easy to follow flow chart of actions.

Training figures were reported at 79% for medical staff, for both child and adult safeguarding training, not meeting the trust target of 90%. Training compliance was better for band 6 and 7 midwives. However, records showed only 67% of staff at band 3 and 5 had completed child safeguarding training.

The head of midwifery was the safeguarding lead and a named safeguarding midwife was also available to staff. Staff reported feeling well supported by the lead midwife who would visit all areas of the maternity unit to ensure any safeguarding issues were addressed and monitored.

To help keep women safe, safeguarding concerns were recorded in the electronic records as an alert. Only staff accessed this information which was not recorded in women's handheld notes. Midwives assessed women's vulnerability at the booking appointment.

There was a specific pathway for children who were under 18 years of age. The pathway helped staff to identify signs of child sexual exploitation.

Staff followed the baby abduction policy and undertook baby abduction drills. This guidance applied to all staff working within the maternity, portering, security and switchboard departments. The baby adduction policy was due for review in October 2021. The last baby abduction drill was in April 2021.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Recent audits showed good compliance with hand hygiene audits showing100% compliance for July and September 2021.

Cleaning records were up-to-date and showed that all areas were cleaned regularly. Cleaning checklists were completed and audited. An antenatal cleaning audit showed 97% compliance in September 2021.

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of personal protective equipment. Hand sanitiser gels were available throughout the service. Staff were bare below the elbow and staff washed their hands appropriately.

Staff cleaned equipment after patient contact. However, labelling of clean equipment was not consistent across all areas.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not ensure women and their babies were safe. Staff did not always manage clinical waste well.

Staff did not always complete daily safety checks of specialist equipment. Staff should check resuscitaires daily to ensure they are working correctly. A resuscitaire combines warming therapy along with the components you need for clinical emergency and resuscitation. All resuscitaires had gaps in the recording of important daily checks. In total 104 checks had been missed from three resuscitaires from June to September 2021. In two of these records, more than a week had passed without a check.

Maternity

The unit had two resuscitation trollies, one on labour ward and one on Tangmere ward. The resuscitation trolly on Tangmere ward included out of date equipment. Despite this, the daily checks had been completed and documented as correct which meant the checks were not effective. This presented a risk that equipment might not be working in the event of an emergency and mothers and babies could be harmed

Equipment did not always indicate when the last service was undertaken, or when the next was due. We checked 17 pieces of equipment and found one hoist, one pulse oximeter and five thermometers did not indicate when they were last serviced.

Staff did not always dispose of clinical waste safely. Several sharps bins were not closed and some had sharps visible above the fill line. We saw anatomical waste in the dirty utility room with the door wedged open on labour ward. The anatomical waste was in a tub with no lid so the waste was visible and uncovered.

Substances hazardous to health were not stored securely. On labour ward the clinical waste room had the door open and not locked. In the room was a cupboard that had a lock but was open with the key in the door. Chlorine tablets were stored within the unlocked cupboard that could have been accessed by patients or other unauthorised people. We also saw a bleach solution on the shelf.

A clinical storage room was unlocked with further unlocked storage cupboards. There were scalpels stored and labelled which patients or other unauthorised people could access.

The service had suitable equipment to help them to safely care for women and babies. On the birthing unit there was only one resuscitaire between two delivery rooms. The unit had recently purchased five new resuscitaires which would help to ensure consistency of equipment and increase the number of available across the department.

Equipment was provided to assist staff with the safe removal of a woman from the birthing pool in an emergency. There was a flow chart and protocol on the wall behind the birthing pool. However; on the main delivery suite pool room the net was obstructed by an air conditioning unit and equipment. This could lead to a delay in accessing the evacuation net.

The service had suitable facilities to meet the needs of women's families. The post and antenatal wards were in close proximity and the neonatal unit was on the same floor as the labour ward, which ensured easy access for mothers and babies. The design of the environment followed national guidance. The birthing unit had additional features to support a home from home approach.

There was a main theatre with a separate recovery room on labour ward. If a second theatre was needed there was a room which had appropriate equipment and facilities to ensure safe care, for example, an anaesthetic machine. This room was being upgraded to include better ventilation.

During times of maintenance the main theatres could be used for all elective caesarean deliveries and the second theatre utilised for emergency surgery.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Maternity

Staff completed risk assessments for each woman on arrival, or prior to arrival if women had phoned the unit. Midwives and midwife care assistants used a recognised tool and reviewed this regularly, including after any incident. Women had a named lead professional (midwife or consultant) depending on the risks. Consultant obstetricians were present for difficult births and were located on the labour ward for rapid response if needed.

Shift changes and handovers included all necessary key information to keep women and babies safe. Handovers were well managed and attended by a multidisciplinary team. There was an overview of antenatal women who were in-patients as well as women on the midwifery led unit (MLU) and postnatal women. Safeguarding issues were highlighted which could be clinically relevant. The handover also included a discussion about high-risk women. Staff were encouraged to contribute and there was effective communication and shared learning. They also used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members.

Safety huddles took place in each ward or area and included all necessary information to keep women and babies safe. Handovers included information about women's psychological and mental health.

Staff discussed the importance of all pregnant women supplementing their diet with vitamin D.

Risk assessments took account of vulnerabilities such as ethnicity and living in areas of social deprivation. There was a lower threshold to review, admit and consider multidisciplinary escalation for women from a black and ethnic minority background.

Staff advised women to be aware of their baby's individual pattern of movements after 28+weeks of pregnancy. They used an information leaflet to support these discussions which could be accessed in multiple languages via the trust website. Women were informed about the importance of monitoring their baby's movements and they knew what to do if they had concerns.

Swab counts were performed and signed by two professionals. There were monthly compliance audits of the WHO safer surgery checklist in maternity. Results showed compliance was above the trust target of 90% for the four months prior to inspection.

A recent VTE audit revealed that 97% of the records were compliant with trust guidance.

There was an effective triage system in place that was monitored by midwives although staff did not use a nationally recognised tool to ensure risks were rated consistently. There was a rota to ensure cover and staff followed a template to risk assess women. Every woman that contacted the department was documented in the patient records and a template was used to identify women who called multiple times. If a woman had called four times then a consultant saw them to ensure that there were no underlying issues.

The clinical effectiveness team performed an audit with a specific focus for women in the latent phase of labour who called the triage line. The aim was to look at how they were conducted and documented, and whether the patient was seen face-to-face after their third triage call. An audit of 44 maternity notes from across the care in the latent phase of labour audit 2021 found that overall, 95% (42 out of 44) received latent phase care that was compliant with trust guideline. The clinical effectiveness team put forward recommendations for improvement to practice and patient safety including ensuring clinical staff across all sites exclusively document triage calls for the latent phase on-line and remove paper triage books from use. Staff were documenting triage online and in patient notes during our inspection.

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the modified early obstetric warning score (MEOWS) to identify women at risk of deterioration. These were accurate and care escalated in line with guidance. However, the MOEWS charts were not kept in women's notes which could lead to a delay in escalation.

Midwifery staffing

The service 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. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have enough nursing and midwifery staff to keep women and babies safe. All staff spoke of poor staffing and exhaustion. Several staff members mentioned the unit sometimes felt unsafe due to staffing numbers and the acuity of women on the unit. Midwives had been going above and beyond to work in extremely challenging circumstances. Due to ongoing pressures and lack of leadership across the unit, this had left many midwives exhausted and several had left as a result. Midwives said that they were "anxious to come to work as they did not know what they were arriving to".

The interim head of midwifery and a matron worked across both St. Richards and Worthing Hospital, one at each site daily. They held "hot calls" daily to adjust and amend staffing across the two sites. Staff were often moved from Tangmere ward to labour ward. Staff reported that this meant midwives covering Tangmere ward were left understaffed.

A midwife reported being in charge of 17 women and babies across ante and post-natal wards. There was an instance where a woman had given birth in the antenatal ward (with a midwife present) as there was no available space to deliver on labour ward. The midwife was in charge of the labouring woman and also both antenatal and post-natal wards at the time.

Medical staff reported midwives had been struggling due to staff shortages. They helped out to support the midwives to alleviate some of the pressure.

The number of midwives and healthcare assistants did not match the planned numbers. Community midwives were often used to increase staffing numbers. In July 2020, there were 286.75 hours of band 6 community midwife support on the wards. In July 2021 this figure had significantly increased to 1335.42 hours.

The service had high vacancy rates. There was a vacancy rate of 25% at St. Richards with 36 vacant midwifery posts in August 2021. Staffing numbers had been insufficient for three months.

The service had a high sickness rate of 9.4% at St. Richards in August 2021.

Managers did not accurately calculate and review the number and grade of midwives, midwife care assistants needed for each shift following national or trust guidance. Leaders on Tangmere ward did not monitor staff in line with the trust guidance and had not been using the birth-rate plus tool to input correct staffing levels. They indicated this was because it showed as "red" (indicating staffing levels were not met) and this was demoralising for staff. However, other midwives said they were reviewing staffing and completing the tool every four hours. This showed poor leadership and could leave staff feeling unsupported by the manager.

Maternity

The service had used a high number of bank staff to fill staffing gaps. However, staff were exhausted and although staff supported each other it was evident staff were not volunteering to fill shifts.

The unit had also stopped the government initiative of 'continuity of carer'. The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period. This had been unachievable with the current staffing issues. During August, 38% of women had received full continuity of care. Staff identified women who were most at risk and prioritised them. Staff reported that since it had been suspended that staffing had become much more manageable.

Staffing within maternity services is a nationally recognised concern. The trust reported that low levels of staffing were due to long and short term sickness, COVID-19 related absence, high levels of maternity leave and continuity of carer. The unit had started to address the staffing problems and had recently employed a governance lead. There were also 14 new staff members including some midwives due to start in October 2021. Staff nurses had been employed to help on Tangmere ward. Although they were not midwives they could alleviate the pressure on midwives by undertaking specific roles such as monitoring, taking blood, and routine care.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep women and babies safe. Consultants were on site from 8am to 9.30pm, seven days a week, although they stayed on if there was high acuity on the delivery suite. They completed two delivery suite rounds, one in the morning and one in the evening.

The service was adhering to recommendations outlined in Safer Childbirth (2007), and Standards in Maternity Care (2016) by providing appropriately trained individuals for the provision of safe intrapartum care. Information provided by the trust indicated there was 60 hours of prospective consultant hours on delivery suite for the past six months, meeting the trust target.

The service always had a consultant on call during evenings and weekends. The service had a consultant of the week to give continuity of care to women on the unit.

The medical staff on duty matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service had low vacancy rates for medical staff. The service had over-planned medical staffing so they were above target staffing levels for some middle grade doctors. As a result, they did not use locum doctors often and were able to fill shifts in-house.

Records

Staff kept detailed records of women's care and treatment but were not always clear and easily available to all staff providing care. Records were stored securely.

Women's notes were comprehensive, however, there was several different systems to record patient information. Some records were electronic and others were paper based.

Maternity

Women's notes were stored correctly but did not contain the maternity early obstetric warning system (MEOWS) charts. These were stored separately at the nurses' station as the midwife care assistants undertook this monitoring. Not keeping the MEOWS charts within the women's' record could mean there was a delay in recognising a deteriorating patient.

Prescription charts were accessed on-line and some clinic data was also stored online. The series of different systems meant that note retrieval could be difficult. It was difficult to find and understand required information as this was stored in different places and in different formats.

Records were stored securely. Women's records were stored for six weeks on the midwife led unit (MLU) and for a further three months on site. The clerical team maintained the notes and uploaded information to various systems postnatally.

Record keeping had been discussed at the maternity quality and safety meeting and highlighted as a concern. The service was planning to ensure all records were electronic but there was no date for completion.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The maternity service used an online prescribing and administration system for maternal prescriptions. Prescriptions were legible, named, dated, allergies and weight were clearly documented., time and route of administration were clearly recorded.

Assurance around prescribing practice was provided by daily pharmacist ward attendance. The pharmacist also reviewed discharge medications, Venous Thromboembolism (VTE) scores and booking weights, VTE prophylaxis and crosschecked prescriptions with relevant guidance

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were checked were all stored securely, were in-date and ordered to ensure the oldest medication was used first.

Controlled drugs were stored in locked rooms within a locked cupboard and the checklists and records associated with these were completed correctly.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Staff followed current national practice to check women had the correct medicines. Midwives worked in pairs to administer antibiotics to double check that doses were correct. There were three medicine errors reported since January 2021; all were reported as no harm.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Alerts were highlighted to clinical teams and the clinical governance report detailed progress monthly.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with individual staff members. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff did not always receive feedback more generally from incidents across the trust.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Low staffing was incident reported. In August there were 26 incident reports related to staffing. In total 144 incidents were reported 139 of these were no harm and five were low harm. The service had no never events on any wards. There were 33 incidents currently open as there was a backlog due to staffing issues.

There was a patient safety lead who reviewed and allocated all incident reports. Once triaged, any moderate or higher incidents were reviewed at a weekly panel meeting. The patient safety office was located on the labour ward which meant staff had easy access to talk to the leads if they had any concerns.

Discussions included the grading of incidents. There were examples where an incident grading had been raised after a notes review and discussion with the clinical director. This showed a robust review system.

On labour ward we saw several information boards, one of which was a 'learning board'. These were up to date and could be seen by patients and staff.

Staff reported serious incidents clearly and in line with trust policy. The service reported all births between 22 and 23+6 weeks gestation who sadly did not survive to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)-UK.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Women received a draft copy of the investigation report which gave them an opportunity to ask questions about their incident. Families received final investigation report and were invited to discuss this with the team.

Managers debriefed and supported staff after any serious incident. Staff were offered debriefing sessions by the patient safety lead who had had specific training. Debriefs were held in groups or individually.

Our survey showed that only 43% of staff agreed with the statement 'My organisation encourages us to report errors, near misses or incidents.' With 56% neither agreeing or disagreeing with the statement.

Only 2% of staff disagreed with the question 'When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.' This meant the vast majority reported that they felt the service took action.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Our survey showed that 89% of staff felt encouraged to be open and honest with service users and staff when things went wrong. With a further 11% neither agreeing or disagreeing with the statement. This showed most staff felt the unit was open and transparent with service users.

Staff received feedback from investigation of incidents that they reported. Midwifery staff did not have regular formal meetings to discuss the feedback and look at improvements to patient care. Incidents were discussed at the monthly

clinical governance meetings attended by the triumvirate and matrons for the service. Newsletters contained information on incidents and shared learning. These were emailed to staff. However, staff reported they did not always have time to read and digest the information in the newsletters. In our survey, for the question 'I hear about incidents that happen in my part of the organisation and the learning from them,' only 59% agreed with this statement.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service monitored safety performance. Some of this data was displayed on ward information boards and available to patients. This included information on breastfeeding uptake, post-partum haemorrhage and shoulder dystocia.

Display boards also detailed the units compliance with the recent Ockendon report recommendations alongside other metrics. The Ockenden Report in 2020 was based on the serious failings in maternity care. The report set out recommendations for maternity services to improve safety and included seven priorities from which all NHS trusts must improve.

Information from the maternity dashboard was also displayed. This documented information on several aspects of the service, including number of caesarean deliveries, homebirths and vaginal birth following caesarean section data.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. All guidelines we reviewed followed national guidance. Clear indications at the start of the document referenced recent changes. Policies were dated when reviewed and there was an indication of the next review date. This included reduced fetal movements (review date July 2023), and multiple pregnancy guidance (review date March 2024). There was a central risk assessment which included the updating of policies.

There were protocols outlining how to share guidance with staff.

Staff completed mental health training as part of their mandatory training. Staff were able to describe how they managed patients who may have additional needs in relation to their mental health.

The service was functioning in line with current government guidance in relation to COVID- 19. However, there were no indications of the numbers of people allowed in each area.

Patient outcomes

Maternity

Staff monitored the effectiveness of care and treatment. Outcomes were not always positive for women but action plans ensured poor outcomes were investigated.

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds which allowed the service to benchmark themselves against other NHS acute trusts.

The service used monitoring results to improve safety. These indicators were scrutinised at monthly maternity clinical governance meetings and provided assurance at the executive-led quality committees and trust board quality committee.

Immediate safety concerns were highlighted through the daily safety huddles, incident management and professional escalation.

The service participated in relevant national clinical audits. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Outcomes for women were not always positive. The dashboard for August and the exception reports from July and August 2021, showed that there were 9 women diverted for care from St. Richards Hospital to Worthing. There was a caesarean rate (both planned and unplanned) of 38% for St Richards. The service reviewed all category one caesarean sections in line with the trust's governance processes.

There had been 13 babies born before arrival (BBA) in August. At least four of these were avoidable and two of these were associated with staffing numbers and ward capacity. Normally the hospital reports three or four a month.

The avoiding term admissions into neonatal units (ATAIN) rate at St. Richards was significantly higher during August with 6.6%. The trust is currently undertaking a quality improvement initiative to reduce admission of full-term babies to neonatal units.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work. Staff undertook a competency booklet and worked supernumerary for a period of time until they felt confident and were assessed as competent in their roles. The midwife care assistants had undertaken training to ensure they were competent to undertake observations and maintain the MEOWs charts.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates across maternity were 73%. Annual appraisals were completed by band 7 midwifes for midwives and midwife care assistants. The band 7 midwives were appraised by matrons (currently the interim head of midwifery). The interim head of midwifery had an appraisal with the chief nurse.

The clinical lead held regular appraisals with medical staff. Medical staff also had regular constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff. There was no specific written policy for the support and supervision of midwives. All maternity staff, including midwives, had access to well-being services provided by the trust. There was a professional midwifery advocate (PMA) team and staff had specific support following traumatic events.

The PMA role is a recognised means of supporting midwives, through restorative clinical supervision, now that formal supervision has been discontinued. There were five PMA's in post, and a plan to have eight by the end of 2022.

Eleven members of staff in maternity were mental health first aid (MHFA) trained and able to provide support and signposting to their teams. There was an ongoing training plan to deliver MHFA training to trust staff.

Staff undertook skills drills. Midwives attended the last skills drill In April. These included simulation and debriefing incorporating the trust guidelines for shoulder dystocia, postpartum haemorrhage (PPH) and new-born resuscitation.

Between May and September 2021, the service had held 13 virtual (PRactical Obstetric Multi-Professional Training (PROMPT) sessions and trained 204 staff members. PROMPT is an evidence based multi-professional training package for obstetric emergencies.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Handovers were attended by paediatric and neonatal doctors. There was a good working relationship between these departments to ensure babies were transferred effectively.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were combined antenatal clinics for women with diabetes or obesity.

Specialist midwives were able to support women with specific needs, for example breastfeeding.

Staff across the department worked well to ensure continuity of care if women were being moved from the midwife led unit to the labour ward. Discussions took place during handover that included women across the whole department including antenatal, post-natal and the midwife led unit. This ensured staff were aware of the team needed to support all the women. Staff referred women for mental health assessments when they showed signs of mental ill health including depression.

The hospital was part of the maternal medicine network, led by one of the obstetricians. The purpose of the Maternal Medicine Group was to discuss the management of patients with complex medical problems during pregnancy; share good practice; standardise guidelines and agree regional referral pathways as appropriate and make recommendations to the Maternity Clinical Advisory Group. This work was multidisciplinary and linked with other NHS teams.

Maternity

Is the service well-led?

Requires Improvement

Requires improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills but have had to take on additional roles to run the service, which meant there was a gap in the leadership structure. They understood and tried to manage the priorities and issues the service faced; however due to the staffing levels and staffing structure this was not always possible.

The interim head of midwifery was visible and approachable in the service for patients and staff but the further leadership team could not be identified by many of the midwives and staff we spoke with.

The senior leadership team (SLT) formed a triumvirate that included the interim head of midwifery, chief of service and interim divisional director of operations. The interim head of midwifery had been in post since March 2021. The interim head of midwifery was line manged by the chief nurse. They were supported in their role by two matrons. One matron was based at Worthing Hospital and one at St. Richards Hospital; however; they were currently on long term leave.

The current structure had left gaps in management and day to day running of the maternity services. The interim head of midwifery had taken on the matron's role across both hospitals and in the community in addition to the head of midwifery role.

There were seven band 7 midwifes and a ward manager who supported the interim head of midwifery. A band 7 midwife was in charge of a shift and supposed to be supernumerary to provide leadership and oversight of the maternity services. However, due to current staffing issues they often had to work clinically and so that oversight and leadership had been absent for several months.

Staff commented that "The service is pushed to the limit. Most shifts I feel we work at a potentially unsafe staffing level. I don't feel managers listen or care about staffing concerns".

Staff felt they were not receiving the support they needed. Changes to the unit and plans to help the staffing of the department were not successfully communicated. Staff told us, "The management structure is severely depleted yet with the merger the meeting requests and reports have increased".

Our survey showed that only 49% agreed that communication between senior management and staff was effective. Only 52% of staff reported they were satisfied or very satisfied with the support they received from their manager.

Maternity

The leaders recognised that there was a significant pressure on the staff in the unit and had been making changes to start to address them. Not all staff were aware of these and updates were not cascaded formally. The chief nurse was the appointed maternity safety champion and attended monthly meetings and reported to the board. There was a practice development role advertised and the service had just employed a governance lead to assist with the day to day running of the unit.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Women's health services had a quality and safety strategy dated 2018 for review in May 2021 and which had expired August 2021. Although there was a vision and strategy for the service the recent staffing issues and increase in activity had meant that this had not been a focus of the service.

The maternity strategy was being reviewed and developed to ensure it aligned with the Local Maternity Networks and the National Maternity Transformation programme.

The women's health service approach to quality and safety aligned with the trust approach, but in addition outlined specific quality and safety objectives, leadership arrangements and performance management and reporting structures so everyone working within the service could understand how these quality and safety objectives would be achieved. Regular trust updates and newsletters about the strategy objectives were sent to staff but staff seemed disengaged with the process.

Most staff we spoke with were aware there was a merger of trusts but did not know any specific details or the effect it would have on their working lives or service provision.

Culture

Staff did not feet respected, supported and valued but were focused on the needs of women receiving care. The service generally had an open culture where women, their families and staff could raise concerns without fear.

All staff were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff described working relationships at local levels had been improving. More recently, staff had reported they felt more listened to and able to raise concerns without fear.

We saw examples where staff had felt able and supported to professionally challenge clinical decisions. This included junior members of staff. There was a good working relationship between midwives and doctors and the team communicated well and supported each other.

Staff mostly told us the culture was one of learning, not blame. Staff were women focused and the midwives had helped support each other during the previous few months when staffing and leadership had been stretched. Staff had reported feeling "pushed to the limit" and "exhausted and demoralised".

Some staff felt there was no point in raising concerns because they had experience of being dismissed or feeling that their issues had not been addressed. Although more recently staff reported this had improved with the suspension of continuity of care, to ease staffing pressures.

Maternity

Generally, staff felt their immediate team members and the interim head of midwifery provided them with effective support to do their job to the best of their ability. However, some staff felt communication between senior management and staff was not always effective.

Staff reported “It is an extremely difficult time. There are simply not enough staff. I am pulled from my non-clinical role to work on the wards frequently (even if just to offer a half hour break to a member of staff on a 13 hour shift)”.

Staff were aware there was a freedom to speak up guardian but none of the staff we spoke with had used them.

Governance

Leaders did not operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but did not have regular formal opportunities to meet, discuss and learn from the performance of the service.

The maternity service was part of the women’s and children’s division. The maternity service did not hold formal departmental staff meetings where incidents, risks, performance, guidelines, audits and user experience could be discussed, or fed into divisional meetings. Although there were discussions about these during safety huddles, there was no formalised meeting for staff to receive and pass on feedback.

Our survey revealed that only 32% of staff agreed with the statement ‘The team I work in often meets to discuss the team’s effectiveness.’

There was a series of meetings and access to the trust board. However, there seemed to be a disconnect between what staff on the ground were doing and what was being reported. The triumvirate were aware of the staffing issues but did not show they had a full awareness of how the staff were feeling on the wards.

The board and executive team reviewed the integrated performance report and specific maternity papers relating to national schemes. This included reports such as the maternity incentive scheme and Ockenden report.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected The maternity dashboard was reviewed monthly at the maternity quality and safety meeting and quarterly at the divisional governance review and by the trust board. The monthly governance report also included information on women from minority ethnic groups to monitor outcomes in relation to COVID-19 complications and increased morbidity and mortality rates overall.

The trust had a combined Worthing hospital & St Richards Hospital maternity quality and safety meeting which was held monthly. There was an additional monthly operations and governance meeting. The quality and safety meeting was open to all staff however, no staff we talked to have ever attend these meetings.

Metrics and information from the dashboard was displayed in labour ward but not on Tangmere ward.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had a women's and children division specific risk register. The risk register included a description of each risk, alongside mitigating actions, and any assurances already in place. The possible impact and the review date were also indicated.

Risks that had the potential to affect the safety of patients, staff, provision of services or other risks were considered for entering on the risk register. For risks scored lower risk, regular reviews of the register took place at departmental and or operational level. At operational level the departmental managers reviewed the risks on the register relevant to their area, decreasing or increasing the rating scores as appropriate.

Risks with a high score were monitored at executive level through the divisional integrated governance and performance meetings. A review of this was also taken by the director of nursing, medical director and a non-executive director and with the senior divisional leads at the quarterly divisional clinical governance review.

The top three risks were staffing, breach births not being detected until labour, and the risks to ethnic minority staff in relation to mortality and COVID-19. All three of these risks had action plans in place and were monitored by the triumvirate. The risk registers also included information relating to some of the risks we identified such as staffing challenges and patient recording systems not being integrated.

The maternity service held joint monthly perinatal morbidity and mortality meetings with the children's service. There was good multidisciplinary attendance and a reporting process. This supported escalation of risks and concerns.

The service was engaging with Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. They ensured they actioned HSIB recommendations. There were 19 case referrals to HSIB in the past twelve months. This was a high number within the South-East area. HSIB reports and action plans were discussed in monthly clinical governance meetings.

The patient safety team undertook a review of sepsis management in May 2021. The review was largely positive but identified the need for a regular audit pathway to ensure long term review.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The maternity service had clear performance measures and key performance indicators (KPIs), which were monitored. These included the maternity dashboard and clinical area KPIs.

The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

The service collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities.

Maternity

The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly and patient names were not visible from the ward areas to ensure privacy.

Engagement

Leaders and staff engaged with patients. Staff felt they were not engaged in the service planning or management. They collaborated with partner organisations to help improve services for patients.

Our survey revealed that only 18% of staff felt they were able to meet all the conflicting demands on their time at work. Many staff reported that they were not engaged or included in changes within the department.

Staff groups could not raise concerns at monthly staff meetings; they could only do this via the informal safety huddles.

The friends and family recommended rate for the hospital had fallen to 74% in June. The friends and family score showed the percentage of respondents who would recommend the service. In July there were a total of 19 responses received from antenatal clinic with 100% recommended rate. There were a total of 77 responses received from labour and postnatal wards with 86% recommended rate which is below the trust recommended rate of 95%. There were a total of 10 responses from Community with 100% recommended rate.

The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP). The MVP was in weekly contact with the service. They also had open access to the head of midwifery and quarterly formal meetings with representatives from the trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had been selected as one of a few NHS pilot sites, and to be able to road test the new NHS LGBTQ+ Rainbow Badges scheme.

Following an incident in May 2020 regarding an induction of labour where the breech presentation was not identified until full dilatation, a working party began work which had led to several innovations and on-going improvements. The trust created an initiative to train senior midwifery staff in the use of portable ultrasound scanners, which was partially embedded in clinical practice with the use of a competency booklet. The trust planned to take part in a national trial and undertook a multidisciplinary training session. The aim of the project was to improve clinician confidence and competence in facilitating vaginal breech birth.

Areas for improvement

Action the trust MUST take to improve:

St. Richards Hospital Maternity Services

Action the trust MUST take is necessary to comply with its legal obligations

Maternity

The trust must ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).

The trust must ensure leaders at all levels are supported and leadership improves at all levels across the department. (Regulation 18 (2)).

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

The trust must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. (Regulation 12 (1)(2i)).

The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e)).

The trust must ensure dangerous chemicals are stored correctly. (Regulation 12 (b, d))

The trust must ensure waste products are stored correctly and safely. (Regulation 12 (b, d)).

The trust must ensure consistency with the use of the birth-rate plus tool and escalation policies to ensure safe staffing numbers. (Regulation 17(b)).

The trust must maintain securely an accurate, complete and contemporaneous record in respect of each service (Regulation 17(C)).

Action the trust SHOULD take to improve:

St. Richards Hospital Maternity services.

The trust should monitor the maintenance of equipment to keep it up to date and document this so it is visible for staff.

The trust should make sure that emergency evacuation nets are easily available in pool rooms.

The trust should consider regular formal staff meetings to ensure learning and give staff the opportunity to raise concerns.