Surrey and Sussex Healthcare NHS Trust

East Surrey Hospital

Inspection report

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Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good**
Are services well-led?	**Good**

Our findings

Overall summary of services at East Surrey Hospital

Outstanding ☆ ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location. From page 3 the ratings and information relate to maternity services based at East Surrey Hospital.

We inspected the maternity service at East Surrey Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Maternity services at East Surrey Hospital provided antenatal, intrapartum (care during labour and birth), and postnatal care for approximately 4600 women and birthing people per year. The service comprised of a day assessment and triage unit, antenatal ward, co-located midwifery led birth unit (MLU), consultant-led delivery suite and a postnatal ward. The MLU had 4 rooms each with en-suite bathrooms and a birth pool. The delivery suite had 1 pool available. The service had a higher proportion of women in the 6th most deprived, and 10th least deprived decile at booking compared to the national average.

The ratings from the maternity services inspection did not change the rating of the location overall therefore our rating of this hospital stayed the same.

East Surrey Hospital is rated Outstanding.

How we carried out the inspection

We provided the service with 48 hours' notice of our inspection.

We visited maternity day assessment, triage, delivery suite, the antenatal and postnatal wards.

We spoke with 25 midwives and doctors, 2 support workers, and 8 women and birthing people. We received more than 100 responses to our 'give feedback on care' posters which were in place during the inspection.

We reviewed 10 patient care records, 16 observation and escalation charts and 15 medicines records. During the inspection we spoke with staff including the director of midwifery, head of midwifery, obstetricians, doctors and midwives. We attended handover meetings and safety huddles.

Our findings

Feedback received indicated women and birthing people had mixed views about their experience. Feedback included about concerns about delays, poor communication, and support needing to improve. For example, being spoken to unkindly, short staffing, and not being listened to. Positive feedback commented on the reassurance and care given by staff, especially on delivery suite.

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:

- Staffing levels did not always match the planned numbers, which put the safety of women, birthing people and babies at risk.
- The service was not always visibly clean, and there were times when equipment checks were not completed.
- Medicines were not always managed well, and care records were not always completed.
- Appraisal rates were low for midwifery staff, and junior doctors did not always complete appropriate safeguarding training.
- Leaders did not always implement improvements in a timely way once they had been identified.
- Policies and guidelines were not always in-date and this may have contributed to adverse incidents.

However:

- Most staff had training in key skills, worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well.
- Staff assessed risks to women and birthing people and acted on them. The service managed safety incidents well and learned lessons from them.
- Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women, birthing people, and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services continually.

Is the service safe?

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 and made sure everyone completed it.

There was a comprehensive programme of mandatory training including fetal monitoring, 'Gap and Grow' e-learning (identifying and referring small babies), blood competency, antenatal screening and others. Midwifery staff received and kept up to date with their mandatory training. Ninety-two percent of staff had completed all mandatory training courses

against a trust target of 90%. Staff completed emergency pool evacuation training and the service ran simulations for staff to gain practical experience. Learning and areas of good practice from simulations were recorded and shared with the wider team. There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies.

Medical staff received and kept up to date with their mandatory training. Ninety percent had completed all mandatory training courses.

The service provided Practical Obstetric Multi-professional Training (PROMPT) for emergencies and neonatal life support. Compliance for all staff was above the trust compliance rate of 90%, with an overall average of 92% across modules and staff groups.

Managers monitored mandatory training and alerted staff when they needed to update. Staff said they received email alerts so they knew when to renew their training.

Safeguarding

Staff understood how to protect women and birthing people 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. However, the service did not make sure all junior doctors had appropriate safeguarding training.

Staff mostly received training specific for their role on how to recognise and report abuse. Training records showed that 85% of midwives, 76% of obstetric consultants and 57% of junior doctors had completed Level 3 safeguarding training for adults and children as set out in the trust's policy, and in the intercollegiate guidelines. The trust target compliance was 90%. Staff and leaders said there were high rates of safeguarding cases at the service due to the close proximity to international airports which sees staff caring for large populations of refugees, and families on lower incomes in certain areas of their catchment.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering from significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a maternity specific safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures, and safeguarding records were updated daily when women and birthing people at risk were in the hospital.

Staff followed safe procedures for children visiting the ward.

Maternity

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practiced what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

Staff did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection. They did not always keep equipment and the premises visibly clean, and we saw some staff were not in-line with uniform policy to minimise risk of infection.

Staff did not always follow infection control principles including the use of personal protective equipment.

During the inspection we observed several staff members were not routinely using gloves for patient contact where this was appropriate, and this was an infection risk. In theatres, we saw staff had not adhered to uniform policy and infection prevention and control measures. We escalated this to staff and managers on the day of inspection.

Managers sometimes audited the environment for infection prevention and control risks and in the 6 months prior to the inspection the service was compliant in 11 out of 30 instances (36%), non-compliant in 5 out of 30 instances (17%) and submitted no data in 14 instances (47%). This may not be enough to provide managers with assurance that the environment is kept adequately clean. Audits recognised that bed spaces were not always visibly free of dust, dirt, and bodily fluids which was a risk, and this issue was evident on the day of inspection.

Maternity service areas were mostly clean and had suitable, clean furnishings. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, we found isolated areas of dust, litter, and staining, which we escalated to staff on the day. Equipment appeared clean however, it was not always clear when it was appropriately clean and ready for use as 'clean' stickers were not routinely used. Action plans submitted by the service showed these issues were identified in June 2023 and were not resolved at the time of the inspection.

Leaders completed regular infection prevention and control and hand hygiene audits and data showed hand hygiene audits were mostly completed monthly in all maternity areas. In the 3 months prior to inspection compliance was consistently above 90%. There was 1 audit breach in June 2023 and the ward scored well at subsequent audits. However, there was missing data 25% of the time in the evidence submitted.

The service monitored rates of hospital-acquired infections and sepsis. There were 4 patients treated for sepsis in the 3 months before the inspection. Staff used a sepsis pathway and care bundle to provide safe care to people with suspected or confirmed sepsis. The service had recently noticed an increase in the number of wound infections for women and birthing people who had caesarean sections and were liaising with the trust tissue viability team to try and minimise this.

During the inspection we observed several members of staff completed hand washing effectively and appropriately between patients, and cleaning equipment and bed spaces.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment mostly kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, daily checks were not always completed and some areas of clinical waste were not properly secured.

Maternity

Staff did not always complete daily safety checks of specialist equipment. We found a resuscitaire on the postnatal ward had been checked on 9 out of 12 days (75%) in September 2023 and this may not be enough to provide assurance that the equipment was safe and ready for use in an emergency. We found daily safety checks of some emergency equipment was missing on 9 occasions (66% compliant) in the 4 weeks preceding the inspection. We found significant gaps in daily checking records on emergency equipment on the postnatal ward, on milk and medicine refrigerators, and for ambient room temperature checks. We found hard copies of out-of-date guidelines on emergency trolleys, which we escalated to staff on the day for removal. However, evidence showed the emergency resuscitation trolley on the delivery suite was checked 90% of the time in the previous 3 months.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. Clinical waste was stored in lockable bins whilst awaiting removal however, during the inspection we saw locks were not working on some clinical waste stores which presented a risk to staff and visitors. We escalated this to staff for action; it was not clear if the issue had been reported previously.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people, and their families. There was a bereavement room for families to use when dealing with the death of their baby and the location and design of the room met national recommendations.

The service had enough suitable equipment to help them to safely care for women, birthing people, and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines, and observation monitoring equipment.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration. However, appropriate data collection was not always carried out.

Staff sometimes used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS) however, there were several sets of paper documentation used by the service. This resulted in MEOWS charts regularly being used in the triage area, but not used when women and birthing people were in labour. During labour care, observations were charted on a partogram which allowed staff to track and monitor trends but did not provide a trigger system to assist staff in identifying and escalating deteriorating patients, which presented a risk. We reviewed 8 MEOWS records and found staff correctly completed them in 7 out of 8 cases and had escalated concerns to senior staff where appropriate. The service completed an audit of 16 records in June 2023 to check MEOWS charts were fully completed and escalated appropriately. Results showed 81% of charts were completed which was below the trust target of 90%. Out of 16 records audited by the service, 13 records had MEOWS charts present and 9 of these (69%) had all scores calculated correctly to ensure appropriate review, which was not enough to ensure safe care. The service planned a repeat audit in September 2023.

Staff used an evidence-based, standardised prioritisation tool for maternity triage. The system was implemented by the service in February 2023. The maternity triage waiting times audit for February 2023 to April 2023 showed midwives

reviewed 87% of women and birthing people within the recommended time frames. The service had an audit in progress at the time of inspection, the results of which were not yet known. There was an action plan and review tool used by managers to monitor the progress of implementation of the new system. Staff told us the system worked well for women but the main challenges to successful implementation were staffing, documentation, and environment. This was because the telephone midwife had to work inside a busy staff base which could be noisy and distracting, and during the night there was 1 midwife in the triage area to take phone calls and provide clinical care, which was not in line with recommendations. Women and birthing people using the service during the inspection told us contacting staff for advice was quick and simple and they were happy with the care provided.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was both on paper and on a secure electronic record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

During the inspection we attended staff handovers and found all the key information needed to keep women, birthing people, and babies safe was shared. There were 2 safety huddles per shift to ensure all staff were up to date. Handovers shared information using a format which described the situation, background, assessment, and recommendation (SBAR) for each person. Managers audited the used of SBAR in June 2023 and found SBARs were used in 11 out of 11 records however, staff did not always complete the SBAR proforma in full. Data from the audit showed 88% of SBARs were completed in full, which was just below the target compliance rate of 90% overall. Areas of improvement were identified, such as full completion of the form generally, and consistent use at shift changes on the postnatal ward. Managers compared the results of the SBAR audit between 2021 and 2023 and found use of SBAR had increased from 57% to 88% which showed significant improvement over time.

There was a multidisciplinary team handover at 8.00 am daily, and doctors performed 2 ward rounds on the delivery suite every morning and evening. Audits completed by the service showed occasions where ward rounds had taken place 3 times depending on medical shift changes and ward acuity, which showed a positive response to service needs. Latest national recommendations were for 2 daily ward rounds on delivery suite.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Records for newborns were comprehensive and provided a standardised risk rating system to ensure staff escalated babies appropriately.

The service did not provide a transitional care ward for babies who required more complex care but did not require admission to the neonatal unit. The service used a Neonatal Early Warning Track and Trigger tool (NEWTT) to identify deteriorating babies however, documentation was not always completed in full, and the trigger system was not consistently or appropriately used by staff as per policy. There was a transitional care unit with space for 4 babies on the neonatal unit however, this was used for babies being stepped down from high-dependency care and was not routinely in use for babies from the postnatal ward.

Re-admissions were audited by the service in September 2023 for the inspection. Neonatal re-admissions data showed between April 2023 and August 2023 166 babies were re-admitted to hospital. This equated to a 9.5% readmission rate and the service was not taking sufficient steps to reduce this in a timely way. Maternal readmissions data showed, between March 2023 and August 2023, 35 women and birthing people were readmitted however, effective data analysis to identify any trends or themes was not completed by the service. We noted maternal readmissions data was combined with the data set for neonatal readmissions. It was not evident that the service monitored maternal readmission rates appropriately before the audit was carried out in September 2023 however, the service said a re-audit would be performed in January 2024. After the inspection, the service provided us with evidence of ongoing quality improvement

projects regarding neonatal readmissions. This included infant feeding advice services for both inpatients and outpatients, a tongue tie service, and a feeding strategy group. The service told us that re-admission rates were monitored by the patient safety team via incident reporting and governed through ATAIN (Avoiding Term Admissions Into Neonatal units) meetings.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Leaders monitored maternity 'red flags' which are a sign that something could be wrong with staffing. 'Red flags' included delayed induction of labour, delay in administration of epidural, a lack of a supernumerary delivery suite co-ordinator, and failure to achieve 1-to-1 care in labour. The service started using an electronic acuity tool in May 2023 which collected red flag data. Between May 2023 and September 2023, the service recorded 267 red flag events, and red flag events were recorded on 20% of occasions. However, red flag data is captured 4 hourly and therefore repeated red flags may relate to one single concern. Leaders told us robust processes were in place to monitor staffing and acuity, and we saw evidence that 1-to-1 care in labour was provided in 100% of cases between May and September 2023, which showed responsive management of acuity on delivery suite.

During the inspection we saw patient flow through the unit was being delayed by discharge processes on the postnatal ward. This impacted negatively on patient and staff experience, and presented a risk that women and birthing people were not in the right area of the unit to receive appropriate care. We saw evidence this had led to delays in induction of labour, and appropriate transfer of women and birthing people to the delivery suite. This problem was reflected in 2022 results from the CQC Maternity Survey for the service, which scored worse than expected in the question about delayed postnatal discharge. We escalated this to managers on the day of inspection who told us this was a known risk on the service risk register and there was an active audit in progress to aid an improvement plan.

Managers audited the use of the World Health Organisation (WHO) safer surgery theatre checklist. We asked for the most recent audit and the service provided documents dated October and November 2022, which was out-of-date. This data showed the theatre checklist was completed effectively most of the time. However, during the inspection we found WHO checklists were documented in several places which could make ongoing oversight less effective.

Managers monitored safe fetal monitoring in labour using a quarterly audit. Results for April to June 2023 identified a number of areas for improvement, including inconsistent use of the electronic fetal monitoring (also known as cardiotocograph or CTG monitoring) interpretation stickers, categorisation of the CTG, appropriate risk assessment, and 'fresh eyes' reviews, which showed 67% and 76% compliance, respectively. There was an informal action plan to improve compliance submitted with the data. The data showed that CTG traces were safely reviewed and categorized 56% of the time which was not enough to assure the service that fetal monitoring in labour was safe.

Managers monitored compliance in relation to Saving Babies' Lives Care Bundle v2 (SBLCBv2). There was a rolling audit for element 1 of the care bundle around reducing smoking. Audits between April 2023 and June 2023 showed good compliance with documenting smoking status at booking (98%) and carbon monoxide monitoring at booking (96%). However, compliance rates were consistently poor for metrics measured at subsequent appointments such as smoking status and carbon monoxide monitoring at 36 weeks gestation (33%). Of 8 women and birthing people identified as smokers at 36 weeks, 3 (37%) were referred to smoking cessation services appropriately. The 5 people who were not referred did not always have clear reasoning for why a referral had not been made, and this put women and birthing people at extra risk of complications relating to smoking or high carbon monoxide levels in pregnancy. The audit

highlighted that an obstacle in achieving higher compliance with carbon monoxide monitoring was availability of equipment. After the inspection the service provided evidence of action planning and mitigation of risk around carbon monoxide monitoring, supply issues and resources in relation to SBLCBv2. Out of 10 actions, 2 were ongoing and 8 (80%) had been completed and resolved.

Element 2 of SBLCBv2 aims to reduce the impact of fetal growth restriction and the service submitted an audit of all babies born with undiagnosed growth restriction between July 2023 and September 2023. The audit showed 4 out of 6 babies had the required ultrasound scans and no abnormal measurements were detected. The service used this information to prompt a case review by sonographers to identify learning which was due to be presented at the trust board. However, the findings were a repeat of audit results in July 2022 and therefore it was not clear that learning or mitigating actions had taken place or been effective.

However, during the 6 months before the inspection the service reported 3 stillbirths over 22 weeks gestation which was between 1 and 2 stillbirths per 1000 births. This was well below the national rate of 4 per 1000 births. There were no stillbirths that occurred during labour. The service reported deaths using the Perinatal Mortality Review Tool (PMRT) and held monthly meetings to discuss them, as well as holding meetings as needed in response to a death.

The service referred all appropriate cases to the Healthcare Safety Investigation Branch (HSIB) and there had been no cases for referral in the 6 months before the inspection.

Staff were aware of the process to open additional theatres in an emergency, and staff checked emergency equipment was safe and ready to use. There were effective processes in place to staff additional theatres when required.

The service conducted a survey about the advice women and birthing people received on fetal movements and analysed the information for trends, themes, health inequalities, and areas for improvement to ensure that the service provided the most effective information.

Staff had access to transcutaneous bilirubinometers (a non-invasive device used to measure jaundice levels in babies) both in the hospital and in the community setting, and this reduced the risk of readmission for treatment, and need for slower, invasive testing.

The service did not close the maternity unit however, in times of high acuity women and birthing people were diverted to neighbouring trusts on a case-by-case basis. The service had diverted people on 8 occasions in the 12 months before the inspection.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. There were perinatal mental health midwives who provided care and support to women however, we saw workload for them was high and there was not always a suitable clinical space for them to work from. After the inspection, the service said workload had been higher due to staff sickness. Staff completed or arranged psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women, birthing people and babies at risk. However, managers mitigated risk appropriately and the service had appointed a recruitment and retention lead.

Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between May and September 2023 there were 267 red flag events, the 3 main categories were delayed induction of labour, supernumerary status of the shift co-ordinator, and delayed or cancelled time-critical activities such as admission to theatre or medical review. We saw staff monitored acuity and reported incidents where low staffing levels were a contributing factor.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 214.17 whole-time equivalent (WTE) midwives and support workers Band 3 to 8, compared to the funded staffing of 190.02 WTE. This was a shortfall of 24.15 WTE staff. Since the review, the service had increased its funded WTE and had been working to recruit more staff. There was a workforce plan in place, and as of September 2023 the service employed 176.55 WTE against a funded template of 216.13 WTE. This was a deficit of 39.58 WTE. However, after the inspection the service told us 8.3 WTE additional band 3 maternity support workers started in September 2023 and 16 WTE band 5 and 6 midwives started in October 2023.

There was a supernumerary shift co-ordinator allocated to be on duty around the clock who had oversight of the staffing, acuity, and capacity however, it was not always possible for the shift co-ordinator to remain supernumerary which meant there was not always clinical oversight of the unit in order to keep women, birthing people and babies safe. To support the supernumerary status of the shift co-ordinator, the service said maternity staff had 24hr access to a senior midwifery manager on-call. In addition to the manager on-call rota, the service used a 'hands on help' on-call rota to enable additional midwifery support during times of peak activity.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

The number of midwives and healthcare assistants did not always match the planned numbers. The service used a daily acuity tool to monitor and manage staffing levels safely. The service shared acuity data from August 2023 which showed staff shortages 36% of the time, and the service was between 3 and 6 midwives short 3% of the time. Evidence showed between June 2023 and August 2023 the service used 566 bank shifts in the acute area.

The service monitored sickness rates and turnover. In the 6 months before the inspection, there was up to 8% staff sickness however, this had reduced to 4% by August 2023. The overall vacancy rate at the time of inspection was 17%.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

Staff said there were not enough midwives, and managers routinely needed to organise staffing levels across the unit to mitigate risks of short staffing. Staff said rotas were examined regularly in advance, and throughout each shift to ensure the safety of women, birthing people and babies. Staff told us this contributed to exhaustion and low morale, and that more could be done to aid retention especially for newly qualified staff. The service had a low vacancy rate for specialist midwives overall however, the service was in the process of transitioning leadership and interim staff were in post at the time of inspection.

Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Maternity

Managers did not support staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives with learning and appraisals. Data showed 64 staff had appraisals in the 12 months before the inspection, which was approximately 37%. This was significantly below the trust target of 90%. The service collected data as a year-to-date figure which meant it was difficult for them to be assured on levels of compliance. After the inspection, the service told us the way data was collected was going to be changed to reflect compliance more clearly. However, there was a tracker system in place for managers to monitor performance quarterly against the compliance target. Data showed compliance with appraisals had improved by 86% for the same period in the previous year.

Managers made sure staff received any specialist training for their role. There were development programmes for nurses, maternity support workers, and midwives who wanted to take on extra roles.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction. However, the service was reliant on locums to fill the middle-grade doctors rota.

The service had enough medical staff to keep women, birthing people and babies safe. There were 18.75 WTE consultants employed by the service however, not all consultants provided obstetric on-call cover. Consultants provided on-site cover on the delivery suite daily from 8.00 am to 10.00 pm on weekdays, and 8.00 am to 5.00 pm at the weekends. Outside of these hours, a consultant was on-call, and attended delivery suite when required. This was in-line with national recommendations for the size of the unit. The service always had a consultant on-call during evenings and weekends and staff told us consultants were available when needed.

The service relied on locum staff to ensure middle-grade doctor shifts were filled. Between April 2023 and August 2023, locums were used 282 times, this was mainly to fill the middle grade doctor rota. The medical staff matched the planned number. The service had low turnover and sickness rates for medical staff overall.

Managers made sure locums had a full induction to the service before they started work. There was no current standard operating procedure for staff to follow to book and orientate locums to the unit however, there was a draft document awaiting ratification at the time of inspection.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunity to develop. Approximately 91% of medical staff had annual appraisals and this was above the trust target of 90%.

Records

Staff did not always keep detailed records of women and birthing people's care and treatment. Records were spread over several electronic and paper systems which presented a risk. However, records were stored securely and available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The service used a combination of paper and electronic records. We reviewed 10 sets of records and found they were not always clear and complete. Notes spread over several paper and electronic systems created opportunity for omission, inaccuracy, and inconsistency. This had been recognised by service leaders and was on the risk register. Throughout our notes review we

found areas where documentation had not been completed according to professional standards or as per trust policy, including legible notes that were signed and dated, risk assessment completion, carbon monoxide monitoring, theatre checklists, fetal monitoring, and swab counts. This was particularly concerning as there was a never event of a retained swab in February 2023.

Unclear or incomplete documentation was a theme identified within incidents we reviewed between January 2023 and July 2023. The service had a quarterly rolling audit of records in place to monitor the quality of documentation. There was an audit of records specifically in relation to gestational diabetes in progress at the time of inspection, and the service supplied record-keeping audit results from January 2023 to July 2023. Data showed the areas of concern identified by our records review had been previously identified as ongoing issues at the service, which indicated slow response to risk. There was a large group of non-compliant areas including but not limited to venous-thromboembolism (VTE) risk assessment, routine antenatal investigations such as blood pressure, fetal movements and urinalysis, and correct use of MEOWS charts.

When women and birthing people transferred to a new team, there was no delay in staff accessing their records. However, during our data collection process we found similar reports between quantitative and qualitative data about the service which showed issues around effective communication and information. Specifically, medical information not being shared across the maternity pathway.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

During the inspection leaders told us that a new audit tool was being developed to better reflect the audit process over several systems and improve data collection. The service had procured a new end-to-end IT system which had a planned project start date in spring of 2024.

Medicines

The service did not always safely prescribe, administer, record and store medicines. Not all staff completed medicines management training.

We reviewed 15 sets of medicines records on paper and electronic systems, and these were mostly accurate and up to date. However, staff did not document patient weight on medicines charts which presents a risk of prescribing and administering an inappropriate dose of medicine. Some patients whose medicines records we reviewed had been risk assessed for VTE and prescribed medicine, and in 1 case we found a high-risk weight-specific medicine had been administered without a documented weight on the chart. This was unsafe practice.

We saw evidence of a medicines safety audit on delivery suite that was done the day before the inspection and no concerns were identified. This was a risk because it had not identified concerns found on inspection the following day, and therefore was potentially ineffective.

Staff did not always store and manage medicines safely. The clinical rooms where the medicines were stored were locked and could only be accessed by authorised staff. However, we found some medicines were out of date and 1 drug room was hot which can impact on the effectiveness and shelf life of medicines. We asked the service to provide evidence of what had been done to manage the temperature in this room as staff were unsure if mitigations were taken, however, this was not received. The service provided a copy of their heatwave policy.

We found hard copies of out-of-date guidelines on emergency medicines, which presented a risk that staff would give inappropriate care. We escalated this to staff on the day for removal. We found significant gaps in the safety checks for

several emergency medicines boxes throughout the unit. The service used 'grab bags' for staff to use in emergency situations and some of the documentation of checks on these was incomplete or absent, therefore the service was not assured that medicine 'grab bags' were ready for use. In theatres we found some medicines were stored in unlocked cabinets and were not routinely countersigned to ensure accurate stock management and safe administration, and this was not risk assessed.

The service provided medicines management training but did not make sure everyone completed it. Training rates were 54% of midwives and 57% of doctors. There was a comprehensive medicines competency test for staff.

Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, we found areas where daily refrigerator temperature checks were missing.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines.

Staff had access to clear midwife exemptions policy and guidance to ensure prescription and administration of medicines within their professional remit.

Staff learned from safety alerts and incidents to improve practice.

Incidents

Incidents were not always categorised or harm-rated appropriately, and a new reporting system was being embedded. However, staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

We reviewed incidents reported by the service between January 2023 and July 2023 and found incidents were regularly rated as lower harm than appropriate, for example massive obstetric haemorrhage and obstetric anal sphincter injury. However, we saw evidence to show the service appropriately monitored incidents for themes and learning. Incidents reviewed showed themes regarding incomplete or unclear documentation and leaders said work to improve this was ongoing. The service implemented a new incident reporting system in the month before the inspection and identified a reduction in reporting since. We saw there was an average of 50% less incidents reported the month before inspection, and managers told us that work to support staff to report incidents was ongoing. Staff said there had been minimal training and support prior to the new system being launched, and this presented a risk that incidents may not be reported appropriately whilst the new system was embedded.

The service had one 'never event' in April 2023 of a retained swab. Managers investigated appropriately and had identified improvements that were ongoing at the time of inspection. Managers shared learning with their staff about never events that happened in the trust and elsewhere. Staff received feedback from investigation of incidents, both internal and external to the service.

Maternity

There were 3 maternity-related serious incidents reported by the trust from 1 February to 8 August 2023. The incidents related to 1 intrauterine death (stillbirth), a foreign object left in-situ post procedure, and the unexpected collapse of baby after discharge, which was subject to a Healthcare Safety Investigation Branch (HSIB) investigation. These incidents were reported and managed appropriately and in line with trust policy. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment.

There were 4 open serious incidents at the time of inspection and 3 of these were over 60 days old. This was because incidents were due to be presented to the trust's complex case review panel for final approval. When serious incidents happened, staff had a debrief which included members of the multidisciplinary team, a rapid case review was conducted, and the service produced a 72-hour report. Further investigations then took place before presentation at the complex case review panel, and any learning or improvements were identified and cascaded to staff. We saw detailed case reviews that provided comprehensive overview and identification of issues, duty of candour, learning and improvement from incidents.

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. Staff could describe what incidents were reportable and said use of the electronic reporting system was improving.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. There was a clear policy for managing, escalating, and investigating incidents.

Managers reviewed incidents potentially related to health inequalities.

Staff understood the duty of candour. They were open and transparent and gave women, birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

There was evidence that changes had been made following feedback from incidents.

Is the service well-led?

Requires Improvement ↓↓

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women, birthing people, and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Maternity

The service was in the process of a leadership change at the time of the inspection, a new Head of Midwifery was recently in post and there was an acting interim Director of Midwifery who was familiar with the service. Staff said the change in established leadership had been a surprise, but that the transition had been managed well overall and staff described positive changes at the service.

There was a Divisional Chief, Divisional Director, and interim Director of Midwifery, who were supported in leadership of the service by a General Manager, Clinical Director, Divisional Risk Lead, and new Head of Midwifery. There were matrons, consultants, and a consultant midwife, as well as human resources, financial and pharmacy lead roles.

Leaders were visible and approachable in the service for women, birthing people, and staff. Leaders were well respected and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions who were both executive and non-executive directors. The service had evidence to show frequent, regular ward safety visits and resulting actions, for example, an increased incentive for bank shift payments to alleviate staffing concerns, the effectiveness of the triage system, and the purchase of new furniture.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply the vision and strategy and monitor progress.

The service had a comprehensive vision for what it wanted to achieve and a precise and well-organised strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy was published in 2023 and provided a 3-year plan up to 2026. The service's main objectives were providing a safe service with a culture for learning and improvement, addressing health inequalities and implementing ATAIN, work with service users, personalised and woman-centred care, and building a sustainable workforce. The vision and strategy demonstrated the service's understanding of the local population. They had developed the vision and strategy in consultation with staff at all levels, and staff could explain the vision and what it meant for women, birthing people, and babies. The strategy contained specific actions to identify and tackle health inequalities that affected the local population and looked at service performance against national equality initiatives such as the Workforce Race Equality Standard (WRES).

There was a separate, comprehensive 'Case for Change' document to specifically deal with challenges involved with levelling out perinatal outcomes for women and birthing people in Crawley, where a large proportion of the service's deprived population reside. The service had implemented a specific board to drive progress against the case for change strategy. The case for change was a collaborative initiative between several local service providers and stakeholders which included mental health, primary, and urgent care services as well as the former local clinical commissioning groups (CCGs).

There was a trust-wide strategy that encompassed maternity services for 2023 and 2024 which included 5 main deliverables: patient flow, staff appraisals, community networking, data capture and financial efficiency.

Maternity

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply the vision and strategy, and monitor its progress.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families, and staff could raise concerns without fear.

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team, and felt able to speak to leaders about difficult issues or when things went wrong. Results of the 2022 NHS Staff Survey were mostly positive, staff described a positive and friendly culture where managers and colleagues were kind, caring, and showed respect for individual differences. However, the survey showed staff had concerns about staffing, exhaustion at work, and a lack of ability to make improvements happen. Leaders told us there were a number of ways they had mitigated the negative feedback, including restricting out of area bookings and increasing pay incentives to encourage staff to fill bank shifts.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service, and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process, and an inclusion midwife in post. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance contained an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Women and birthing people received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes, shared feedback with staff, and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Maternity

The trust policy was to process, respond and close complaints within 25 days. Between February 2023 and July 2023 the service received 30 formal complaints, and 18 of these were managed in a timely way according to trust policy. Between April 2023 and June 2023 there was 1 complaint that was not closed within 25 days.

In the 2022 NHS staff survey 2 out of 7 scores for the 'people promise' elements had declined significantly compared to 2021 scores: staff engagement, and morale. Leaders told us work had been done on staff wellbeing including the refurbishment of a rest room, and clinical psychologists being made available to support staff after any adverse events.

The 2022 CQC Maternity Survey found the service performed as expected in 47 questions, and better or somewhat better than expected in 2 questions. There were 2 questions where the service performed worse than expected and this has been commented on elsewhere in the report.

The trust submitted data to the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). In WRES data, 2 out of 9 metrics showed statistically significant differences between White staff and staff from ethnic minority groups. WRES data was discussed at governance meetings and worked into the service vision and strategy. WDES data showed notable differences between the experiences of staff with a long-term condition or illness compared to staff without. This indicated poorer working experiences for staff with long-term conditions or illnesses.

Governance

Leaders did not have full oversight of the rate of change required for governance processes and procedures to be effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders worked with partner organisations. The service had a governance structure that intended to be supportive of the flow of information from frontline staff to senior leaders. However, leaders did not always monitor key safety and performance metrics and make improvements without delays and risks still occurring.

Maternity and divisional governance meetings were led by the interim Director of Midwifery, a Divisional Director, and a Chief of Service. This leadership team were supported by the new Head of Midwifery, a team of matrons, and obstetric consultants. Maternity leadership fed up into 4 executive level committees dealing with business planning, performance, quality surveillance, and safety. There were executive and non-executive maternity safety champions who had direct lines of communication between the trust board and service-level staff. The board subcommittee was responsible for maternity assurance, and this fed up into the public and private board.

The maternity triumvirate leadership team had informal weekly meetings that were not minuted, but the service provided an overview of discussions in the last 3 meetings which included divisional objectives, workforce census, senior medical vacancies, and performance review.

Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

There were monthly consultant meetings that were minuted to discuss any service issues and these covered both obstetrics and gynaecology. Consultants routinely discussed concerns and challenges around the middle-grade doctors' rota which presented a challenge to fill appropriately. It was evident that consultants identified and discussed service issues however,

there were no documented actions to resolve issues within the minutes, therefore processes may not be effective to properly mitigate risks. For example, it was not clear what measures had been put in place to improve middle-grade doctor staffing and there were no clear improvements noted with this. After the inspection, the service provided evidence that action logs were kept following meetings for example, sub-meetings were held to discuss medical staff job planning and tackling appointment waiting times. The presence of action logs was reassuring; however, some actions were not always updated. We saw 2 actions had been completed and closed.

There were monthly board meetings for the Women and Childrens' Health division which were minuted. There was evidence to show leaders identified and recognised challenges and worked to improve or resolve them including record keeping, security, and medicines concerns. The board monitored complex case reviews (serious incident investigations), overdue incidents, patient safety outcomes, complaints, safeguarding, and duty of candour alongside key performance 'scorecard' categories such as Avoiding Term Admissions Into Neonatal units (ATAIN) and readmissions.

Matron meetings took place informally every 2 weeks and these meetings were not recorded however, the service provided us with an overview of discussions that have taken place at the meetings between June 2023 and August 2023. The overview provided showed a comprehensive level of discussion and information sharing around concerns and improvements however, as the meetings were not minuted it was unclear how the service was assured on the effectiveness of the meetings.

The service used a project tracker to maintain oversight of progress against 'Better Births' (2016) maternity transformation report. The service monitored progress against recommendations made in the Ockenden Reports (2020 and 2022) and was compliant in all immediate safety recommendations, and leaders said work was ongoing for the additional recommendations made in the 2022 report.

Clinical guideline groups took place monthly to discuss and approve new care guidelines and identify guidelines that require updates. Out of 133 guidelines there were 44 (33%) that were due for update, including unassisted birth, neonatal resuscitation, management of newborn hypoglycaemia and hypothermia, maternity high-dependency unit care, and additional elective caesarean lists. Some guidelines were due for review since 2019, and some out-of-date guidelines and standard operating procedures may have had an effect on serious incidents that had occurred. We saw that some guidelines had been updated but reference lists had not, which may indicate a lack of appropriate evidence review to ensure guidelines contained current best evidence-based practice.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues. They had plans to cope with unexpected events. However, identified actions to reduce the impact of risks were not always closely monitored to ensure improvement was achieved in a timely way.

The service had a clear escalation policy for times of high acuity which supported staff to manage and communicate workload in the safest way. The Operational Pressures Escalation Levels (OPEL) framework was used and set out clear pathways to action and mitigate risk.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve outcomes.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through audits, the incident management system, and staff. They were reviewed and recorded in meeting minutes for the monthly risk assurance meeting.

Maternity

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made. Managers shared and made sure staff understood information from the audits. The leadership team however, did not always oversee timely completion of required actions to make change where risks were identified. For example: for infection prevention and control, equipment purchases, scanning, record keeping, and readmission rates.

The service audited use of the Neonatal Early Warning Track and Trigger tool (NEWTT) and presented findings to the divisional quality board. Results of the audit in June 2023 showed documentation was not always completed in full and the trigger system was not consistently or appropriately used by staff as per policy. The plan to mitigate this risk was to create a staff learning update, the effectiveness of this was not yet known. The documentation stated the learning update should be implemented by September 2023 where babies were not always escalated to relevant professionals when their observations were abnormal; this time frame presented an additional risk.

The service had developed an action plan in response to infection prevention and control issues that were identified in June 2023. The document showed a comprehensive awareness of issues facing the service and several areas of concern had been actioned and resolved. However, some tasks were marked as complete on the day before the inspection, or had not been completed or actioned between June 2023 and September 2023. Despite the action plan being in place since June 2023, we did find infection prevention and control concerns during the inspection which may indicate some governance processes required strengthening. We saw remedial works being carried out around the maternity unit on the day of inspection.

The service identified electronic fetal monitoring as an area of risk through audit in February 2023, and implemented a rolling audit to monitor progress and improvement over time. The initial audit results set out action plans to achieve quality improvement and provide leadership oversight. However, during the inspection we completed a notes review and none of the records were completed in full in relation to CTG monitoring.

There was a service risk register to monitor and manage emergent and ongoing risks. We saw evidence that top risks were staffing, delayed induction of labour, and theatre capacity. We saw risks were regularly marked for review. After the inspection, the service shared the risk register mitigating actions and forward planning, which showed clear dates for review and management plans. Service leaders had recognised a problem with patient flow through the unit which affected the top risks documented. They had increased the number of beds available to ease pressures from patient flow and introduced a new flow co-ordinator role to effectively manage the problem.

The service had a low rate of stillbirth compared with the national average and there were robust processes for recording and managing investigations via the PMRT pathway. When investigations found improvements in care were required, these were implemented swiftly by the service.

The service audited national metrics including compliance against newborn screening tests which showed 100% of babies received appropriate screening.

The service had a triennial training plan in place to ensure delivery of effective training, with a specific strategy to monitor progress against. The service worked to co-produce a homebirth emergencies training day with the local ambulance service which provided an opportunity for professionals to collaborate and learn together, promoting communication. The training day was open to external professionals working within the local maternity and neonatal system (LMNS).

Maternity

The service reported an increase in postpartum haemorrhage over 1500mls since February 2023 and in April 2023 recorded a rate of 40 per 1000 births, compared with the national figure of 29 per 1000. We asked leaders about this on inspection who described mitigations that had been developed in response, including processes for midwives to measure blood loss, first line treatment for bleeding, training, and a quality improvement project. The service was also participating in a study on postpartum haemorrhage care.

There was a monthly meeting to discuss admissions to the neonatal unit and identify areas for learning and improvement under the service's ATAIN plans. The 2 most recent meetings before the inspection had improved discussion and note-keeping which made clear when babies would have been able to stay with their parents had there been true transitional care provision. This supported the service with a business case to develop transitional care which was in progress at the time of inspection.

Leaders had assessed the service response to midwifery continuity of carer as recommended in the 2022 Ockenden report. The service suspended continuity of carer due to staffing concerns however, following recruitment projection, had produced a comprehensive plan to recommence continuity of carer when staffing allowed throughout 2024, with a particular focus on tackling health inequalities. This demonstrated measured oversight of risks and a focus on continual improvement.

The service engaged with HSIB investigations and referred cases appropriately. The service developed considered action plans to implement improvements following any HSIB case and any recommendations. A small number of recommendations from HSIB reports in the 12 months before inspection were for improvements that did not impact the outcome of the cases investigated. There were regular, externally reviewed PMRT meetings, and the bereavement team met every 2 months to discuss service improvement.

Leaders monitored red flag events and safe staffing levels. There was a manager on-call system and specialist midwives worked clinically if required. Leaders said supernumerary status of the shift co-ordinator had been incorrectly over-reported and training had been provided to prevent this. The service provided 1-to-1 care in labour to 99% of women and birthing people between May 2023 and September 2023, the remaining 1% were babies born before arrival to hospital. Leaders concentrated on staff retention and recruitment and a working group was created to perform exit interviews with staff leaving the service to learn from and improve retention.

The service monitored inhalational nitrous oxide gas (Entonox, used as pain relief in labour) following a national patient safety alert. Use of Entonox was suspended until levels were tested and maintained safely and a new air filtration system was installed. Trust response to the problem was comprehensive and timely, and service leaders communicated well with women, birthing people, staff, and stakeholders to keep them informed whilst issues were resolved.

There were plans to cope with unexpected events. The service had a local business continuity plan.

Information Management

The service collected data and analysed it. Staff could mostly find the data they needed to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. However, several paper and electronic systems were used, and records were not always complete which impacted finding and analysing accurate data.

The service collected data and analysed it. They had a live dashboard of performance data which was accessible to senior managers. Key performance indicators were displayed for review and managers shared this information with the LMNS for external benchmarking.

Staff could mostly find the data they needed to understand performance, make decisions and improvements. However, as records were not always completed in full, this impacted on leadership ability to monitor performance. The digital information systems were encrypted and secure.

Data or notifications were consistently submitted to external organisations as required.

The service had procured an end-to-end IT system which was due for initial implementation plans starting in Spring of 2024, with the aim of alleviating issues and risk in information management.

Engagement

Leaders and staff actively and openly engaged with women, birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Local MVP co-chairs described positive working relationships with staff and a positive appetite for change and improvement at the service. MVP meeting minutes showed progress against strategic actions on the workplan which covered a comprehensive task list including but not limited to engagement, patient information, and strategy group meetings.

The service held birth workers' networking events to discuss provision of maternity services and encourage positive collaboration between trust-employed midwives, maternity service managers, the MVP, and external birth workers such as doulas, breastfeeding support workers, independent midwives, and others.

The service made interpreting services available to women and birthing people and collected data on ethnicity.

Leaders understood the needs of the local population and tailored services according to them. The service had implemented a transport service to ensure women and birthing people who lived in areas that made access to the hospital difficult could attend scans and appointments more easily.

Leaders monitored 'family and friends' questionnaires and shared results of the survey between April 2022 and March 2023 with us. These results showed an overall decline in scores from December 2022 to March 2023, including in cleanliness, information, and respect. After the inspection, the service provided family and friends questionnaire results from June to August 2023. These showed women and birthing people said their care was good or very good in 93% of cases. Evidence showed the service did respond to complaints and concerns, including changing handover processes to make them more private and ensuring lights on the postnatal ward were switched off in good time to allow patients to sleep.

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.

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. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement lead who co-ordinated development of quality improvement initiatives. Staff

told us there were several quality improvement programmes in progress including a focus on health inclusion, inequalities, and deprivation which had led to development of new community outreach clinics and work with local refugee populations. Staff said there were more ideas being developed and costed to continue improvement in this area of practice, with support from the LMNS, NHSE, and the trust executive team.

The service had identified limitations of 72-hour complex case reviews being conducted using medical records and guidelines only, and introduced 'After Action Reviews' (AARs) which provided a collaborative working space for staff and families to improve care together. Families were involved from the start of the AAR process and the service had implemented positive changes to practice as a direct result of this.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies and were participating in studies including but not limited to areas such as breech birth, twin pregnancy, induction of labour with hypertension, large babies, and smoking cessation methods. In the 2022/2023 financial year the service increased its research participation by 75% and implemented midwifery led research.

Leaders used incident reviews to identify areas of learning and developed safety messages and topics for annual training days to ensure continued evidence-based practice.

Outstanding practice

We found the following outstanding practice:

- There was an inclusion midwife in post and the service had a specific focus on promoting equality and diversity for staff and patients, and tackling health inequalities. Leaders monitored incidents and outcomes for health inequalities and ethnicity to ensure women, birthing people and babies were not put at additional risk because of their ethnicity or personal circumstances. Each policy and guideline contained an equality statement to ensure nobody was disadvantaged by its contents.
- The service had implemented a 'Case for Change' in Crawley with local stakeholders and services to improve access to maternity care for disadvantaged parts of the population. This included the set-up of new outreach clinics, joined services, hospital-funded transport and more.
- The service worked well with their local Maternity Voices Partnership, who took on strategic roles within the Local Maternity and Neonatal Systems (LMNS) and worked on innovative ways to engage with local populations, including women and birthing people who are difficult to reach.
- The service identified areas for improvement and worked with families to effect positive change following incidents, in particular, the introduction of 'After Action Reviews'.

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:
East Surrey Hospital maternity services

Maternity

- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
- The service must ensure infection prevention and control measures are effective and completed. Regulation 12 (2) (h)
- The service must ensure medicines are stored, managed, prescribed and administered safely. Regulation 12 (2) (g)
- The service must ensure action is taken to resolve identified shortfalls from audits with clear timescales for improvement. Regulation 17 (2) (c)
- The service must ensure all documentation is completed in full, including but not limited to swab counts, fetal monitoring reviews, and MEOWS/NEWTT charts. Regulation 17 (2) (c)
- The service must ensure all junior doctors receive appropriate safeguarding training. Regulation 13 (2)

Action the trust SHOULD take to improve:
East Surrey Hospital maternity services

- The service should ensure that governance processes are strengthened, including but not limited to implementing improvements in practice in a timely way following safety concerns being identified, accurate monitoring of readmission rates, and timely review of guidelines and policies.
- The service should ensure to minimise and mitigate the impact of short staffing.
- The service should ensure incidents are categorised correctly by severity and harm-rating.
- The service should consider implementing a second daily consultant ward round on delivery suite as per national recommendations.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors. The inspectors were supported by 2 midwifery specialist advisors and 1 obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.