University Hospitals Sussex NHS Foundation Trust

Worthing Hospital

Inspection report

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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 Worthing Hospital

Outstanding ☆ ➔➔

We carried out this unannounced focused safety inspection of maternity services provided by University Hospitals Sussex on the 28 September and 4 October 2021 because we received information of concern about the safety and quality of the service. At our last inspection in 2016 we rated the maternity service as outstanding.

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 other regulatory bodies.

We asked the trust to send an anonymous staff survey to give all maternity staff the opportunity to share their experience of working at Worthing 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 Worthing Hospital and there were 26 responses. The anonymous results have been used as evidence to support our report.

Western Sussex Trust merged with Brighton and Sussex NHS trust in April 2021 to from University Hospitals Sussex NHS Foundation Trust.

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.

We only inspected maternity services at Worthing Hospital as this was the area of concerns from mothers and staff. The concerns raised related to the numbers of staff, poor patient experience, and the quality of care delivered.

We did not inspect any other core service. We are monitoring all other core services.

As a result of our inspection findings CQC have taken enforcement action and told trust to improve the service.

Our rating of services went down. We rated them as requires improvement.

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 findings

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 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 (Bramber ward), and spoke to the community nursing team.

We spoke to over 20 staff to better understand what it was like working in the service including senior leaders, midwifes, obstetric staff, medical staff, maternity support workers, housekeepers, student midwifes and the patient safety team.

A team consisting of an inspection manager, two inspectors and two CQC specialist advisors undertook the inspection at Worthing Hospital.

We reviewed ten sets of maternity records and six 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.

Medicines were not always stored securely.

Staff were not undertaking daily and weekly safety checks in line with national guidance and trust policy.

The triage service was not formally risk rated which meant mothers had their individual risks assessed in a subjective way.

Staff did not always have time to report incidents and did not always receive feedback from incidents reported.

Leaders had the skills to run the service, but had to take on additional clinical roles 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.

Governance and risk management processes were poorly understood by most staff. Most of the breaches identified at inspection were directly or indirectly related to poor staffing levels.

Staff morale was low, and the workforce was exhausted.

However:

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

Local leaders on the Worthing Hospital site were visible, approachable, and led by example.

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 staff investigated poor outcomes. Doctors, midwifes and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families, and carers.

Staff felt valued by their immediate teams' members and told us the emphasis on team working brought them pride and helped with their resilience.

We observed collaborative and respectful relationships between medical and midwifery staff.

Maternity

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 but not all staff were able to complete it.

Most staff completed their mandatory training modules. Over 90% of staff had completed their mandatory training. Training modules included fire, infection control, information governance, adult and child safeguarding, health, safety and risk, equality and diversity, basic life support. However medical staff training compliance was below the trust target in all mandatory modules.

However, other key training modules had low levels of compliance. For example, midwife compliance for cardiotocograph (CTG) was 53% and doctor compliance 87%. This meant a large number of staff had not received CTG training.

There were electronic systems to monitored mandatory training compliance. Leaders also monitored training compliance.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse.

The head of midwifery was the safeguarding lead and a named safeguarding midwife. Staff felt supported by the lead midwife who visited all areas of the maternity unit to ensure any safeguarding issues were addressed and monitored.

To help keep women safe, staff recorded safeguarding concerns 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. Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

There was a specific clinical pathway for children 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. However, these drills had become infrequent. 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 trust informed CQC of their intension to review this policy and standardise it for use across all sites.

Maternity

Medical staff received training specific for their role on how to recognise and report abuse. However safeguarding training compliance in this group of staff was 79% which was below the trust target of 90%.

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 appeared clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. Recent audits showed good compliance with hand hygiene audits showing 100% compliance for July and September 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed national infection and prevention guidance. Hand sanitiser gels were available throughout the service. Staff were bare below the elbow and staff washed their hands in line with World Health Organisation guidance.

Cleaning records were up-to-date and showed all areas were cleaned regularly. Cleaning checklists were completed and audited. Antenatal cleaning audit showed 87% compliance on the labour ward and 95% on Bramber ward in September 2021.

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 kept people safe. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. There were omissions in the check logs for the emergency resuscitation trolley and resuscitaires. A resuscitaire is a device used in labour and delivery procedures has a combination of consumables, oxygen, and a warming platform used in emergency situations. On Bramber ward the resuscitation trolley was not tamperproof and did not have a list of the emergency equipment held therefore it was difficult to check thoroughly. There was no resuscitation team oversight of this trolley and it was not subjected to routine auditing. The trust responded to our inspection findings and provided assurance all emergency equipment was now checked after the inspection.

Women could reach call bells and staff tried to respond quickly when called. Whilst we did not see any delays on the day of inspection, staff told us they prioritised clinical care tried to minimise delays. However, they told us it was not always possible to respond swiftly if staffing levels were low.

A clinical storage room was unlocked with further unlocked storage cupboards which contained intravenous fluids, injection consumables and medicines. This was easily accessible by unauthorised people which meant there was a risk of tampering or misuse.

Maternity

The design of the environment supported service delivery. There were single rooms with on suite facilities on the labour ward. However, the bereavement room on this site was not a suitable environment. There was a small sofa, a table, sink, and tea making facilities. In one corner there was a small desk, computer and a large shelf displaying bereavement information was visible. This space did not lend itself as a sympathetic environment for bereaved parents.

Clinical waste was managed in line with trust policy.

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

The Modified Early Obstetric Warning Score (MEOWS) was designed to allow early recognition of physical deterioration in women by monitoring their physiological parameters. This tool was used to help identify mothers at risk of deterioration. However, these charts were not kept by the bedside but in a separate folder in an office. This meant that clinicians did not have easy access to these important records. It also meant the valuable information for new mothers which was printed in the MEOWS documentation was not readily available for them to read.

There was a maternity triage system that was monitored by midwives although staff did not use a nationally recognised tool to ensure risks were rated consistently. Activity data showed not all call contacts to triage were recorded on the electronic system.

Shift changes and handovers included all necessary key information to keep women and babies safe. Handovers were managed well 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.

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

Swab counts were performed and signed by two professionals. There were monthly compliance audits of the World Health Organisation (WHO) safer surgery checklist in maternity. Results showed compliance was 85% which was below the trust target of 90% for the four months prior to inspection. We found were a small number of incomplete WHO audit forms in medical records.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff undertook 'Fresh eye' reviews in line with national guidance. The use of Fresh eyes is a mechanism used in some NHS maternity services as an attempt to mitigate against the potential of adverse outcomes in labours where intermittent auscultation is used to monitor fetal wellbeing. Staff documented Fresh eye reviews in medical records.

Maternity

Staff knew about and dealt with any specific risk issues. Venous Thromboembolism (VTE) risk assessment compliance was between 93% and 98% at Worthing Hospital for the last six months.

The unit had a clinical effectiveness team who performed a range of audits to check how the unit managed risks in line with national guidance.

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.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Staffing levels and skill mix were regularly reviewed although the numbers of staff were rarely sufficient to meet the needs of the service.

The service did not have enough nursing and midwifery staff to keep women and babies safe. Staff accurately calculated and reviewed the staff numbers, grade and skill mix, the rotas showed the unit was short on most shifts. A total of 17% of staff who responded to our survey told us they were able to meet all the conflicting demands on their time at work.

The unit used a staffing tool to help analyse safe staffing numbers. The staffing tool had not been reviewed for some time. This meant there was no assurance the staffing numbers the tool was set to measure was correct to meet the needs of the service or the current surge in activity. Data showed an increase in birth activity. For example, August 2021 showed an increase of between 30-40 births more than the previous year. Data showed staffing levels in September 2021 only met the template 41% of the time. This meant the unit was running with low staffing levels 59% of the time. Staffing levels in August 2021 was very challenged. It was widely accepted the current template was insufficient to meet demand. The trust had commissioned a Birth-rate plus staffing review at the time we inspected.

Staff routinely undertook an acuity assessment every four hours but felt it was a pointless task because the unit was always short staffed.

Staff we talked with all told us they were working at their limits and doing all they could to ensure mothers received safe care and treatment. Mothers received 1:1 care whilst in labour. However, this meant staff were working longer and not always having breaks. The pressures faced by the service meant staff where staff did not have capacity to undertake their roles.

Staff repeatedly told us they were very worried about safety on the unit because of the lack of staff. The unit relied on bank staff to give extra support. However, the bank service did not always fill shift vacancies. Staff told us they did additional bank shifts driven by wanting to support their colleagues, but they also told us they were now so 'tired' and 'exhausted' they were no longer able to help. Some staff told us they were actively seeking alternative employment.

Bank staff employed by the unit had a full induction and tended to have long term placements. This provided continuity of care standards because the bank staff was familiar with the policies, procedures and systems on the unit.

Maternity

Medical staff reported midwives had been struggling due to staff shortages. They actively supported the midwifery teams to try and alleviate some of the pressure.

At busy times community midwifes were asked to work on the unity to support staff and maintain safety. However, this was not ideal because this meant community provision was reduced. It also meant that on occasions staff worked a full day and then had to return to work to help during their on-call hours. The service also used specialist midwifes to backfill the vacancies on the unit.

Staff provided feedback to the senior leadership team which indicated very low staffing levels and concerns for safety. The trust responded by stopping the government initiative of 'continuity of carer' programme and reallocating the staff to work on the unit and community midwife teams. This started on the 27September 2021.

Maternity support workers in Worthing worked differently to the other units. For example, they currently did not undertake clinical observations. This meant midwives did not always have the support they needed to work effectively. The trust was working with the staff side union to resolve this issue.

The service had 18 current vacancies and six staff on maternity leave. The trust had employed 14 new midwifes to work across both sites in West Sussex. The positive impact of these additional staff will take time to be apparent on account of inductions, supernumerary periods, and ongoing supervision to reach required levels of competence.

Midwife sickness, including staff isolating due to COVID-19, was 11% in August 2021.

The trust reported staffing and safety concerns twice weekly to systems partners to allow ongoing oversight of the increase in acuity and poor staffing levels. Staffing data was presented at the quality and safety meetings but was not formally reported to the trust board. There was a plan to incorporate maternity staffing within the trusts safer staffing monthly reports.

The trust recruited new staff from overseas. We expect this to have a positive impact on the service in the coming months.

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.

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.

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.

Maternity

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 systems used did not support contemporaneous record keeping. Records were stored securely and but not always available to those providing care.

The service stored medical records securely. However, they were not always easy to locate. Staff told us not all staff used the electronic tracking software which meant it was sometimes a challenge to locate notes. On the day of the inspection, it proved difficult to locate the records we wished to review. However, when we returned to Worthing Hospital on Monday 4 October the trust provided all the medical records we requested for review.

The unit had a combination of paper and electronic record systems. However, the electronic system did not always support staff to record events when they happened and sometimes required staff to complete or print records in retrospect. Staff told us there was one person at the trust who was available to help with the system; however, this did not prevent staff from having to work on records in retrospect. This was a potential risk to records continuity given the low levels of staff and the needs to prioritise clinical care.

Calls from mothers were not always recorded on electronic systems.

Women's notes were comprehensive, but not all staff could access them easily.

Medicines

The service did not always safely administer and record medicines. Medicines were not always stored in line with national or trust guidance.

Staff did not always follow systems and processes when safely administering, recording, and storing medicines.

Medicines were not always stored securely; we found an intravenous medicines cupboard unlocked and vials of intravenous medicines unattended on a work top.

Staff did not always store Oxygen and Nitrous Oxide cylinders securely in line with national guidance or trust policy.

Staff did not always check controlled drugs on the unit in line with trust policy. We saw seven gaps on the check ledger for August 2021 and two gaps for September 2021.

The medicines storage room had a temperature checking system. However, we noted 14 occasions where staff did not check the temperature in September 2021. Most checks showed temperatures of 20-25.5 degrees which exceeded the recommended manufactures' guidelines for some medicines so there was a risk of medicines having reduced efficacy.

The post-partum haemorrhage (PPH) medicines grab box contained a drug which is not used for the treatment of PPH. This meant there was a risk of mothers receiving an incorrect medicine in an emergency. We did not see any PHH guidance or algorithm for staff to follow in an emergency. This meant staff did not have access to easy to read guidance.

The sepsis grab box contained three out of four medicines that were out of date. There was a note that indicated replacement medicines were ordered but they had not been replaced in a timely way. This meant there was a risk to mothers of receiving out of date medicines. The trust responded to our inspection findings and provided assurance all medicines were checked after the inspection.

The medicines administration charts (MAR) showed staff did not always administer regularly prescribed medicines. This was mostly related to pain relief. The charts did not contain a reason why medicines were omitted. This meant mothers did not always have their medication on time or a contemporaneous record of the rational for omitting medicines documented in line with national guidance.

Incidents

The service did not always manage safety incidents well. Staff recognised and reported serious and moderate harm incidents and never events but did not always report near misses or incidents resulting in low levels of harm.

Staff knew what incidents to report and how to report them. However, due to low staffing levels staff told us they were not always able to report incidents. Staff told us that reporting such incidents often meant having to stay late to complete the incident reports.

Incidents at ward level were reported via the electronic reporting system. Incidents were then reviewed and escalated to the clinical governance lead. All incidents rated moderate and above was escalated for review to the Quality and Safety meeting. A report was then generated to go to Quality and Safety Group and the Maternity Safety Champion as well as the Maternity leadership safety lead.

There was concern some incidents were not being graded appropriately. Staff told us they had concerns about incidents reported as moderate harm, but which had severity levels downgraded to low harm without a detailed review or explanation. Staff told us they were seriously concerned about this practice, and it affected their level of confidence in reporting practice.

Our survey showed that 95% of staff agreed with the statement 'My organisation encourages us to report errors, near misses or incidents.' A total of 78% of the staff surveyed felt safe to report concerns.

Our survey showed that 71% of staff felt encouraged to be open and honest with service users and staff when things went wrong. With a further 10% neither agreeing nor disagreeing with the statement. This showed most staff felt the unit was open and transparent with service users.

Our survey showed 74% of staff agreed with the question 'When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.' However, 26% of staff neither agreed or disagreed or strongly disagreed. This meant the majority reported that they felt the service acted but there were some staff who did not feel this was the case.

Staff told us they did not always received feedback from the investigation of incidents 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,' 39% disagreed with this statement.

Managers debriefed and supported staff after any serious incident. Staff involved in traumatic events had access to supervision, mental health, and TRiM support. TRiM is a peer delivered system of risk assessment and ongoing support designed specifically to assist in the management of traumatic events.

There were no ever events reported in the last 12 months.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women, and visitors although not all staff were aware of this.

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

Whilst the service collected data and displayed it for staff, women, and visitors however, the data on display in the unit was not current and dated March 2021. This meant staff and women did not have the most up to date safety information available to them

Staff were not aware data was displayed on wards for staff and patients to see, so could not use to understand performance.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

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. The staff newsletter contained information for staff when a national policy changed or was updated.

Maternity

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.

Patient outcomes

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 routinely 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.

There had been 13 babies born before arrival (BBA) in August. Normally the hospital reports three or four a month. The trust reviewed all 13 cases and found nine cases were unavoidable and two were associated with staffing numbers and ward capacity. The remaining four cases had a root cause analysis completed. There were no systemic issues found and no harm identified in all cases. An action plan and ongoing monitoring process are in place.

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. A record for all inductions was kept.

Staff had annuals appraisals of their work. However, staff told us they felt like it was a tick box exercise rather than a meaningful conversation about their personal development and career progression.

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

There were systems to identify staff training needs; however, there was little time or opportunity for staff to develop their skills and knowledge due to low staffing levels.

Maternity

The trust provided staff with specialist training but it was frequently cancelled due to low staffing levels. On the day of the inspection the practice development midwife was providing skills drills for the community midwife team and a small number of staff were supported to attend. The trust had a band five preceptorship programme and practical obstetric multi-professional training which held staff gain key skills in maternity care.

The staff were actively supported by the clinical educator. The service had recently recruited a practice development lead to provide additional learning and development support for staff. Both supported the learning and development needs of staff.

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.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred women for mental health assessments when they showed signs of mental ill health, including depression.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

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.

Is the service well-led?

Requires Improvement

Maternity

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 current 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.

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 divisional director of operations and had a professional reporting responsibilities to 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. In mitigation of the absence a clinical governance role was created to support the interim head of midwifery.

The senior leaders at Worthing Hospital were constantly trying to manage the poor staffing levels and frequently working clinically and undertaking many front-line roles. This showed solid support for staff but it meant they were unable to undertake their leadership roles and safety oversight of the unit.

All staff spoke well of their immediate managers and leaders. Most staff felt supported, listened to, and felt able to raise concerns. Staff had approached leaders and raised serious concerns about behaviour and culture. These concerns were listened to and addressed which had significantly improved their confidence.

Our survey showed that only 46% agreed that communication between senior management and staff was effective and 39% of staff reported they were not satisfied with the support received from their manager.

Most comments in the staff survey related to poor staffing, low morale, and a worry that 'something bad will happen.' Staff also told us they generally felt supported by my managers when they had the time, but managers were also very over stretched and under too much pressure. This was thought to affect their ability to fully support their staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, but staff were not engaged with this. The vision and strategy were focused on sustainability of services and aligned to local plans.

The service had a vision and strategy; however, staff views were not aligned with it, and they were disconnected from its delivery. This was due to the staffing crisis which gave little or no time to consider the service's vision or strategy. Staff told us their primary concern was delivering safe care to mothers and caring for their colleagues.

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, 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.

Maternity

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 generally felt respected, supported and valued by their immediate senior leaders. They were focused on the needs of patients receiving care although some complaint responses were not appropriate in tone. The service generally had an open culture where staff could raise concerns without fear although they were not always confident action would be taken.

During the inspection staff told us they worked in a supportive and nurturing culture since the recent change in leadership.

There was a multidisciplinary approach to the care delivery. Medical and midwifery staff spoke about working together to ensure safety and give a positive experience for mothers.

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 slightly since the suspension of the continuity of care programme, to ease staffing pressures. In our survey most comments about leaders and managers were complimentary. However, there were some comments which indicated a staff perception of favouritism and being 'silenced' when raising concerns.

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

Our survey asked staff how satisfied they were with how the organisation treats people with respect and take action to reduce bullying and harassment. 73% of staff said they were satisfied. However, 17% staff who told us they experienced bullying and harassment but did not report it.

We were contacted by two members of the public who raised concerns about their care and treatment. We reviewed both complaint responses from this site and found they lacked empathy and did not reflect the trust's values. Neither response addressed all the concerns and questions outlined in the original complaints. After our inspections the trust has reported all complaints are reviewed and signed off by the chief nurse to ensure they are of the highest standard.

Governance

Leaders did not operate effective governance processes. Staff at all levels were unclear about their roles and accountabilities and did not have 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.

Staff did not understand the systems or their roles in them to ensure good governance.

Maternity

We reviewed the obstetrics and gynaecology integrated operational management meeting meeting minutes and found they lacked a structured agenda, and the minutes were sparse. There were no formal timelines recorded to complete or monitor actions.

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.

There was a system to manage an investigate complaints. A recent change in process meant all complaint responses were signed off by the chief nurse The quality of the responses was variable.

The service had recruited a new governance lead to help improve governance.

The trust was preparing to launch a new governance strategy in the months after the inspection.

Management of risk, issues and performance

The service and teams used systems to manage performance effectively. Current systems for managing risk were not kept current. They had plans to cope with unexpected events.

The service had a 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. However, not all staff were aware of the risk register, it is location on the trust drives, it is function or the recorded risks. This meant that staff were unable to manage risks as they were unaware of them.

The risk register was last updated in 2019 so the service could not be sure it captured all current risks and that mitigations remained appropriate and effective at reducing risks. Current systems to review risk were not working or effective.

Risks with a high score were monitored at executive level through the divisional integrated governance and performance meetings. A review was also undertaken 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 service was engaging with Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. They ensured they actioned HSIB recommendations. There were 19 case referrals from the whole trust to HSIB in the past twelve months. This was a high number within the South-East area. Stakeholders discussed HSIB reports and action plans in monthly clinical governance meetings.

The trust had an up to date business continuity plan. Staff were aware of their roles in the event of an unforeseen event.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure but did not always function effectively. Data or notifications were consistently submitted to external organisations as required.

The trust operated an electronic and paper-based records systems. We found the electronic patients record systems did not always support staff to maintain a contemporaneous care record because of connectivity or system glitches. It relied on a pressured workforce to enter data and print records in retrospect. This was identified was a significant risk to the service.

Clinical records were not always easy to find. Not all staff used the records traceability software, which meant finding notes was sometimes a challenge.

Data stored by the trust remained confidential and stored securely at the Worthing Hospital site. 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.

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 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.

Engagement

Leaders and staff engaged with patients. Staffing levels meant staff did not feel engaged with the service. They collaborated with partner organisations to help improve services for patients.

Outside of the pandemic leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. However, this level of engagement was affected by the pandemic and the current staffing shortage.

The unit had restarted collecting feedback from mothers in the months before the inspection.

We saw thank you cards displayed from others who had a positive experience on the unit.

The friends and family testing had been reintroduced. Comments reviewed were mostly positive. however, we noted a number of comments relating to breastfeeding support that may indicate this as an area for development.

Maternity

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 unrestricted access to the head of midwifery and quarterly formal meetings with representatives from the trust.

Team meetings did not always happen due to low levels of staffing. This meant that staff did not have an opportunity to raise concerns or hear key messages about their service

The trust used a range of communication tools to aid learning and development. This included newsletters, emails, hot topics. However, staff did not always have time to read or engage in these methods of communication because they were prioritising clinical care. This meant during busy times the usual communications tools used to share learning and key messages was having little impact.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services, but staffing challenges prevented them from participating fully in quality improvement activities.

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.

Leaders encouraged innovation and participation in research. Some staff were actively engaging with the research programme undertaken.

The trust relied on the Patient First programme as a service improvement tool. However, staff told us that service improvement and engagement with the Patient First programme was difficult due to the current pressures.

Although staff were committed to and going above and beyond to deliver a high standard of care, and were passionate about innovation and improvement, they felt they had no capacity to do anything other than clinical care due to the low staffing levels

Areas for improvement

Action the trust MUST take to improve:

Worthing Hospital Maternity Service.

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 to provide effective leadership (Regulation 18 (2)).

The service must improve staffing levels and maintain safe staffing levels; the service must ensure consistency with the use of the birth-rate plus tool and escalation policies (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 maintain securely an accurate, complete and contemporaneous record in respect of each service user (Regulation 17(C)).

The trust must ensure the maternity triage services are delivered in line with national guidance. (Regulation 12 (1) (2) (a, b))

The trust must ensure contemporaneous records of medicine administration is kept and medicines are stored in line with national guidance. (Regulation 12 (2) (f, g))

Action the trust SHOULD take to improve:

Worthing Hospital Maternity Service.

The service should ensure all clean equipment is labelled in line with trust policy. (Regulation 12)

The trust should ensure that staff are following guidance when reviewing the severity of incidents. (Reg 17)

The trust should consider how staff get clear feedback when incidents are downgraded to promote understanding and learning.

The trust should consider restarting regular formal staff meetings to improve staff engagement.

The trust should consider ways to improve environment of the bereavement room.

The trust should consider how it could improve complaint responses.

The trust should review maternity support workers job description so it is a standardised role providing effective support.

Our inspection team

The team that inspected the service comprised of one CQC lead inspectors, one CQC inspectors, and two CQC specialist advisors. The inspection team was overseen by Amanda Williams Head of Hospital Inspection.