University Hospitals Sussex NHS Foundation Trust

Princess Royal Hospital

Inspection report

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Haywards Heath
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Date of inspection visit: 28 September to 04 October 2021
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Princess Royal Hospital

Inspected but not rated

We carried out this unannounced focused safety inspection of maternity services, provided by the University Hospitals Sussex (UHS), because we received information of concern about the safety and quality of the service.

Information of concern had been received from several sources about the maternity services across the trust. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

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

We also asked the trust to send an anonymous staff survey to give all maternity staff the opportunity to share their experience of working at UHS and raise and share concerns in a safe and confidential manner. The survey was open to staff between 1 September and 15 September 2021 and at the Princess Royal Hospital there were 57 responses. The anonymous results related to the Princess Royal Hospital have been used as evidence to support our inspection.

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 as requires improvement and well-led as 'inadequate', we did not have enough evidence to re-rate the effective domain.

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

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

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

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

How we carried out the inspection

Our 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 does not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe, effective and well-led.

Our findings

We visited clinical areas in the service including the central delivery suite, the postnatal ward, triage and the day assessment unit. We spoke with members of staff, including service leads, midwives (bands 5-8) obstetric staff (junior-consultant), consultant anaesthetists, maternity care support workers, student midwives and advanced neonatal practitioners.

We conducted a survey of maternity staff prior to the inspection. We observed the morning handover on the delivery suite and the postnatal ward. We observed the multidisciplinary ward round. We reviewed 10 sets of maternity records and 10 medicine charts. We also looked at a wide range of documents including protocols, meeting minutes, risk assessments, grading of recently reported incidents and audit results. 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

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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 did not ensure everyone completed it. Staff told us they sometimes had to complete training in their own time.

Staff did not always keep up to date with their mandatory training. Staff told us that during COVID-19 the majority of training had changed from face to face to virtual. Mandatory training included subjects such as fire safety, infection control and equality and diversity. The compliance rate was 79% which was worse than the trust target of 90%. The compliance rate included data from both sites as this was not available to be broken down by site. Some staff told us that they completed their online mandatory training at home in their own time, as there simply was not enough time to do this whilst on their shift.

Skills drills training (practical training that all members of the team completed together) had been virtual during COVID-19 but had recently re-started face to face. The compliance rate was 51% which was worse than the trust target of 90%. This was broken down into 57% of midwives, 31% of maternity support workers, and 43% of medical staff. Updated information provided after the inspection showed that 60% of midwives had now completed their skills drills training. There was no updated information relating to medical staff. The service advised that there were three further skills drills sessions available in 2021 for staff to attend who were not up to date with this training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff flagged patients who were at risk at handovers. However, compliance with training on how to recognise and report abuse was poor.

Maternity

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. There was a dedicated maternity safeguarding team and the trust provided role specific training for staff. Information provided after the inspection showed that 100% of nursing and midwifery staff had completed safeguarding adults level one training, but only 70% had completed level two training. Safeguarding children compliance was 100% for level two training, but only 74% for level three training. This was worse than the trust target of 90% for mandatory training.

Medical staff received training specific for their role on how to recognise and report abuse, however not everyone had completed it. Data showed that only 50% of medical staff had completed safeguarding adults training, and whilst there was 100% compliance with safeguarding children level two training, there was only 30% compliance with level three training. This was much worse than the trust target of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff identified women in abusive relationships in order to support them and their unborn baby to stay safe. We saw that in eight out of ten patient records, women were asked if they were experiencing domestic abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding concerns were recorded as an alert on the patient's electronic record and were discussed at handovers of care. Prior to the electronic patient record, which had been introduced in January 2021, safeguarding alerts were recorded in the patient notes on a sheet of yellow paper to easily identify that there was a concern. During a handover, a patient was flagged as having a "yellow" alert and the reasons for this.

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. During the inspection we observed domestic staff regularly cleaning the floors and the clinical areas. Staff cleaned bed areas after the patient was discharged to make the area clean for the next patient.

Cleaning records were not up to date in all areas of the unit and so could not demonstrate that all areas were cleaned regularly. On Bolney ward, cleaning audit scores were displayed for May 2021, which was four months out of date at the time of our inspection. The central delivery suite displayed results from August 2021 which demonstrated an overall compliance rate of 99% which was just above the target for very high-risk areas of 98%. The audit was repeated in September and we saw that the overall compliance rate was 97%. We requested further information regarding cleaning audit compliance for the other areas within maternity such as for Bolney and the day assessment unit, however we were not provided with clear results for each area and therefore they have not been included in this report.

Bolney ward displayed an 'infection control' board which advised 'this month's audit result was 100%'. However, it was not clear what the audit entailed, when it had been completed and whether it had been updated.

On Bolney ward, we looked at two birthing pool rooms. In room eight, the cleaning record for the birthing pool was last recorded on 4 June 2021, and in room six, the last recorded clean of the birthing pool was in April 2021. However, the rooms had been used since these dates. Whilst the rooms and birthing pool appeared visibly clean and ready for a patient, the documentation was out of date and this meant there was no assurance to show the birthing pools had been cleaned after each use.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE such as face masks, face shields, gowns and gloves. There were also antibacterial hand gels, as well as handwashing and drying facilities throughout the unit. All staff were bare below the elbows and wearing face masks correctly on the unit. We spoke with two patients who told us that they felt safe on the ward and that staff were visibly cleaning their hands and always wearing PPE.

Staff cleaned equipment after patient contact but did not label all equipment to show when it was last cleaned so it was not possible to know when it was last cleaned and was safe to use. Although we saw staff cleaning equipment after patient contact, there was no indication in the rooms or the bay as to when and how they had been cleaned and by whom.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them.

Mothers and babies were kept secure on the maternity unit. There was secure access to the central delivery suite and Bolney ward. Maternity unit staff could access the unit with a swipe card, and patients and visitors were required to ring a buzzer and advise who they were visiting to be granted access. We observed staff preventing people from 'tailgating' onto the unit.

Women could reach call bells and we observed staff respond quickly when called. Patients told us they felt safe and that although staff were evidently very busy, they were always attentive and helpful.

The matron told us that on Bolney ward the beds did not fit through the side room doors as they were too wide. We were advised this was on the risk register but the cost for changing the door width was too high and therefore was to remain on the risk register indefinitely. The trust was managing this risk with a range of mitigations. This included only using this room for patients who were assessed as low risk and the use of transfer trolleys.

Staff carried out daily safety checks of specialist equipment. However, checks were not always recorded. Resuscitation equipment was visible and accessible and were kept on all ward areas. Trolleys had tamper evident tags and the serial numbers matched those on the checklists. Checks were completed every day. However there were five days from the week commencing 1 September that had been left blank, and therefore it was not clear whether the contents had been checked on these days. This meant staff on these days were not assured the equipment was fit and ready to use.

After the inspection the trust provided CQC with assurance all equipment was checked in line with trust policy.

Some areas and corridors were cluttered, and staff told us there was a shortage of storage space. On the central delivery suite, there were entonox cannisters and a trolley partially obstructing a fire exit.

The service had suitable facilities to meet the needs of women's families. The birth partners of women were supported to attend the birth and provide support. The clinical areas currently had limited visiting due to the pandemic restrictions. There was a dedicated bereavement room called the Butterfly Room which was situated outside of the ward, away from celebrating families and the sound of babies crying. Staff used privacy curtains to maintain women's privacy and dignity when the labour room doors were open.

Assessing and responding to patient risk

Maternity

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. However, staff did not use a nationally recognised tool to prioritise care for women attending triage.

Staff did not use a nationally recognised tool to triage women at risk of deterioration. One midwife was responsible for managing triage on any given shift which meant that if they were dealing with a woman in triage, there could be a delay in answering the phone. Likewise, if the triage midwife was on the phone, there may be a delay if a woman in triage needed her attention. Staff used their clinical judgment to prioritise patients and there was no evidence of a systematic approach to prioritising women who attended triage, for example, by red, amber, green (RAG) rating, in line with best practice. A whiteboard was used in the triage area that was used to maintain oversight of the women present.

Identifying frequent or returning callers relied upon a robust verbal handover between staff and good history taking at each call. We observed a record book with log sheets of calls but it was not clear whether this was uploaded to the patient's main electronic record and was therefore a risk.

We requested the service's triage standard operating procedure or guidelines but were told there were no triage guidelines and to instead look at the day assessment unit which did not provide information regarding the day to day running of the triage area.

Staff undertook the World Health Organisations '5 steps to safer surgery' checklist on patients who required surgical intervention, and this was present in the two records we reviewed of patients who required surgical intervention.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the Modified Early Obstetric Warning Score' (MEOWS) tool and regular monitoring based on women's' individual needs to ensure any changes to their condition or deterioration were promptly identified. We reviewed ten records and saw that all had been completed, scored and escalated where required.

Staff completed risk assessments for women thought to be at risk of self-harm or suicide. All records we reviewed had a relevant risk assessment using nationally recognised questions to assess a woman's risk.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a handover which was comprehensive and identified any risks and patients at risk of deterioration. The handover also included a discussion about any high-risk women and these were discussed as a team. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each patient.

Staff knew about and dealt with any specific risk issues. Staff assessed every woman's risk of venous thromboembolism at booking, on arrival, in labour and during post-natal care in all of the records we reviewed. This was in line with national guidance. They monitored the baby's growth and accurately plotted this in eight out of ten sets of records reviewed.

Carbon monoxide screening, which was part of 'saving babies lives 2016' initiative, was not performed in any of the notes we reviewed.

Midwifery staffing

Maternity

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However there were low rates of sickness and staff turnover.

The service reported that they had enough nursing and midwifery staff to keep women and babies safe during labour, however staff told us they felt the levels were often unsafe. Data showed that between April and August 2021, 100% of births had 1:1 care in labour from a midwife which was in line with national guidance. However, staff told us that they felt staffing levels were often unsafe. To gain feedback from staff in a confidential way the CQC undertook an online staff survey. The online survey ran between 01 September and 15 September 2021. The survey received responses from staff working in maternity at the hospital and included 18 free text comments from staff. Some of these comments from the clinical teams included: “Recent staffing levels below template is having an effect on staff and there is a lack of senior managers seen present on the wards”, “The chronic short staffing of the maternity unit is directly impacting patient care” and “Midwives are persistently understaffed which makes it hard to deliver the appropriate care”

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. However, the number of midwives and healthcare assistants did not always match the planned numbers. We reviewed the rota for the week prior to the inspection (20 September to 26 September) on the central delivery suite and saw that actual numbers were lower than planned numbers in five out of seven days. Data provided following the inspection showed that staffing for the week 4 October to 10 October was below planned levels on at least one shift per day for all seven days. We spoke to staff who told us that this was a regular occurrence.

Triage is the assessment area where midwives take calls from concerned pregnant women who may be experiencing worrying symptoms such as bleeding during their pregnancy or be in early labour. This service is open 24 hours a day, seven days a week. In PRH, one midwife was assigned to triage per shift without any additional support and that when triage became busy or was not staffed due to staff illness, patient calls would be sent straight through to the central delivery suite team for advice. We saw from the rotas provided after the inspection that between 27 September and 3 October, triage was not staffed on 7 shifts out of a possible 21. Between 4 October to 10 October, three shifts out of a possible 21 did not have triage cover.

The ward manager could adjust staffing levels daily according to the needs of women. Managers moved staff according to the number of women required in clinical areas however staff told us this was at short notice.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had low rates of bank and agency nurses. Bank staff varied between four and 10%. Staff told us that working bank shifts had been incentivised with an increased pay reward. Less than 1% of staff were agency. Staff told us that they were disappointed when management told them that agency staff could not be used as they were not familiar with the sites and therefore unsafe. However staff felt that the current state of staffing levels were already unsafe and an extra professional staff could only make things better.

The service had a low vacancy rate. The matron advised that the vacancy rate for midwifery staff was 10%.

The service had a reducing turnover rate. We saw data sent to us following the inspection that showed the turnover rate for midwifery staff had reduced from 12% in March 2021, to 9% in August 2021.

The service had low sickness rates. Sickness rates (which were not broken down by staff group) varied between 3 and 5% per month.

Maternity

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 9am to 5pm, Monday to Friday and the service had a consultant on call during evenings and weekends. Staff told us that medical staff were responsive when calling them in.

Information provided by the trust indicated there was 40 hours of dedicated consultant hours on the delivery suite between April and August 2021, which met the trust target of 40 hours.

Consultant ward rounds were completed in the morning only, with no second medical ward round in the afternoon. This was not in line with best practice.

The service had low turnover rates for medical staff. Data sent to us following the inspection demonstrated that the turnover rate was at 0% in August 2021 for medical and dental staff across both sites.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and staff could access them easily. The majority of women's notes were recorded on an electronic record which staff could update in real time on electronic tablets. Patients who were transferred from out of area still had some paper records.

Records were stored securely. Patient electronic records were on electronic tablets that were password protected.

Some staff felt that updating the electronic record in real time felt difficult whilst still engaging with the patient, and we observed several staff interacting with patients and then going to the office to update the notes on the tablet.

Staff recorded the necessary information. We reviewed ten patient records, and all entries were timed, dated and signed in the electronic record.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed ten medicines charts as part of our patient records review. We found that these were complete, legible, and had all allergies documented.

Controlled medicines were stored in a locked room, in a locked cupboard, which only midwifery staff had access to. A twice daily audit was completed of controlled medicines.

Staff told us that before Covid-19 there was a dedicated maternity pharmacist, however they now had a 'virtual pharmacist' who staff could access by email for queries and concerns about patient medication.

Incidents

The service did not always manage safety incidents well. Staff recognised and reported some incidents and near misses, however did not always report recurring incidents such as staffing incidents. Managers investigated incidents and fed back to individuals.

Staff knew what incidents to report and how to report them. However staff told us that some incidents such as when staffing felt below safe levels, were not always reported because it had become the 'norm'. Staff told us that in order to report incidents, they would have to stay late after their shift, and often they were already staying late. For low level incidents, staff told us they simply did not have the energy to stay even later to report them.

We requested copies of ten incidents following our inspection to review. We were only sent five, of which three were categorised as no harm, one as low harm and one as moderate harm. We saw that only one of the incidents had lessons learned documented.

One of the incidents we reviewed involved a patient who arrived by ambulance and required an emergency caesarean section following the loss of a lot of blood. The baby was born in poor condition and was sent straight to the special care baby unit and then to the trevor mann baby unit at the Brighton site for further specialist input. The incident harm was rated as 'low' and actions to investigate were documented one month after the incident was reported. It was not clear from the information provided whether the harm grading was appropriate and whether it should have been graded as 'moderate' harm.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. In response to the question in the CQC survey: in this organisation, we are encouraged to be open and honest with service users and staff when things go wrong, 70% staff agreed.

Staff received feedback from investigation of incidents. Staff told us this was either via direct feedback on the incident system, through staff meetings or wider learning that was shared via email. Staff reported getting feedback quickly, one example given was that feedback was received the next day. However, of the five incidents we received following the inspection, only one had feedback documented to the reporter.

In response to the question: I hear about incidents that happen in my part of the organisation and the learning from them, 29% strongly agreed, 40% agreed, 14% neither agreed or disagreed% disagreed and 14% strongly disagreed.

In response to the question: My organisation encourages us to report errors, near misses or incidents, 47% strongly agreed, 31% agreed, 7% neither agreed or disagreed, 3% disagreed and 10% strongly disagreed.

In response to the question: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again, 31% strongly agreed, 38% agreed 12% neither agreed or disagreed, 5% disagreed and 12% strongly disagreed.

Maternity

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

Safety Data Safety Data

The service used monitoring results to improve safety. Staff collected safety information but did not share it with staff, women and visitors.

Safety data was not displayed on wards for staff and patients to see. Although safety data was monitored it was not displayed for staff and patients to see. Records showed the maternity dashboard reviewed data for the organisation, activity, workforce and clinical indicators.

Is the service effective?

Inspected but not rated

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff did not follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Several policies and protocols we reviewed were over the date for review. This was identified on the risk register however the controls were: "MDT meeting between governance and obstetric leads to ensure participation from colleagues to review and update guidance in a timely manner." There were no actions listed against the risk or any indication of how many policies and protocols were out of date and progress of updating these. There was also no indication whether the policies had been prioritised for update. As a result, staff did not always have access to the most up to date guidance and policies to guide their practice.

We reviewed minutes from a meeting titled, 'Actions arising from the external panel review in response to NHS Resolution (NHSR) concerns for RSCH and PRH' dated 4 May 2021. This had also identified an issue with maternity guidelines being out of date. It stated that 33 out of 76 policies were out of date.

During the inspection, we observed a patient have an artificial rupture of membranes (ARM), a procedure to break a women's waters, on the antenatal ward with no plan to transfer them to the delivery suite in a timely manner. We asked to review the protocols for ARM but none of them specified the process to be followed to ensure a woman on the antenatal ward was appropriately monitored until moved to the delivery suite. One of the Health and Safety Investigation Branch (HSIB) recommendations for the trust was to ensure that the guideline provides staff with a clear pathway of care and a process to monitor ongoing risk for women being induced – this had not been completed.

The service did not always follow current government guidance in relation to COVID- 19. Although, staff wore appropriate PPE and patients told us that they and their partners were tested regularly, not all rooms or areas had indications of the numbers of people allowed in each area to aid social distancing.

Competent staff

Maternity

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

Staff were not experienced, qualified or had the right skills and knowledge to meet the needs of women. Compliance with training and competencies in cardiotocography CTG (electronic monitoring of baby's heart rate) were low with only 50% of midwives up to date with their training. This was much worse than the target of 90%. This had been identified as an issue via the HSIB who had advised one of the recommendations for PRH was to ensure that there was consistent use of the fetal monitoring categorisation tool (including 'fresh eyes' review) and that all staff were supported to recognise CTG concerns.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to a student midwife who told us that they had an orientation to the area when they started working on the unit. A maternity care worker we spoke with told us that there was an induction which had been quite thorough but also felt rushed.

Managers supported midwifery staff to develop through yearly, constructive appraisals of their work. The service sent us information following the inspection that showed 82% of midwifery staff (including maternity support workers and nursery nurses) had received an appraisal. We did not however receive details of medical staff appraisal rates.

Managers supported staff to develop through regular, constructive clinical supervision of their work. A team of twelve Professional Midwives Advocates (PMA) were shared between the Royal Sussex County Hospital and Princess Royal Hospital and provided restorative clinical supervision for midwives.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Student midwives told us that there was often no continuity of midwifes for learning and development. They felt the work given to them was at the appropriate level generally. Occasionally they were asked to do things which were not appropriate and had to repeatedly tell the midwife what they are and not capable of. Once told, they were supported to learn. A midwife told us it was difficult to get the midwifery ongoing record of achievement (MORA) signed off because of staff shortages. Other staff members also spoke of difficulty in getting competencies signed off due to staffing levels.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women, however ward rounds were not always multidisciplinary. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. In some areas, we observed good multidisciplinary working, such as on Bolney ward during handover between midwives, midwifery care assistants, associate neonatal nurse practitioners and nursery nurses. However, we observed a ward round on the delivery suite and noted that only the consultant attended, there was no midwifery input and whilst there was an anaesthetist available, they did not join the ward round.

Skills drills training was multidisciplinary, in line with best practice and staff of all grades and disciplines attended.

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.

Maternity

Is the service well-led?

Inadequate ↓↓

Our rating of well-led inadequate. We rated it as inadequate.

Leadership

Leaders at a local level had the skills and abilities to run the service. However senior leaders were not engaged with staff. They did not manage the priorities and issues the service faced. They were not visible or approachable enough in the service for women, and staff. They did not support staff to develop their skills and take on more senior roles.

Maternity was part of the Women and Children's Division which covered the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The director of midwifery (DoM) post was vacant at the time of inspection. The head of midwifery (HoM) was cross-site and covered both the Princess Royal site and the Royal Sussex County site in Brighton and in the absence of the DoM post, reported directly to the Chief Nurse. There was an inpatient matron and a community matron, and a governance and safety lead who reported into the HoM.

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

Staff told us that the senior team, up to the matron, were approachable and supportive. Staff members described the matron as a 'breath of fresh air" and "engaged and supportive". However above matron level, staff were not sure they would recognise if the head of midwifery or executive team were on the ward. Staff told us that when the head of midwifery was on site, they stayed in their office and did not come out to see or speak to the staff.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey prior to the inspection. The survey ran between 1 September and 15 September and there were 57 responses from maternity staff working at the PRH. In response to the question 'communication between senior management and staff is effective', only 24% of staff agreed. In response to the question: How satisfied are you with the support that you get from your immediate line manager, just over 50% of staff said they were satisfied.

The trust had twelve Patient Advocate Midwives who covered the east side of the trust. Their role was to supervise and support midwives. They continued to deliver this role to the midwives even though they felt unsupported by the senior leaders.

The trust assured CQC the leadership concerns were being reviewed and monitored.

Vision and Strategy

Staff were not aware if the service had a vision for what it wanted to achieve and a strategy to turn it into action.

Maternity

The trust had a vision and strategy that was displayed on the trust's website. Their mission was 'excellent care every time'. They describe all their efforts to do this put the interests of their patients first and foremost, and are underpinned by their values:

Compassion, Communication, Teamwork, Respect, Professionalism, Inclusion. The trust state "These values were selected by our staff, patients and public when we were talking about the merger and the sort of organisation we want University Hospitals Sussex to be. They combine the values of both Western Sussex Hospitals and Brighton & Sussex University Hospitals and added an important new focus on inclusion."

PRH was one of four hospitals that formed a merger to create University Hospitals Sussex on 1 April 2021. Staff told us that whilst they were aware of the merger, there had not been much communication about how this was going to work in the future and particularly about how this would impact individual sites. One staff member commented "This has never felt like one trust, now it feels like four".

Culture

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

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff told us that the unit was a close team, and that they supported each other. Examples given included supporting a new midwife who felt overwhelmed on their shift and adjusting the rota so that they could complete the shift alongside a senior midwife. Staff advised that the matron would 'scrub up' and help when they were short staffed.

Some staff told us that they felt undervalued by the senior team and not listened to. Examples were given where changes in the rota system meant that staff could not request or change some shifts. This meant that often staff were working shifts that did not support their work-life balance.

Staff told us they felt able to raise concerns with their immediate managers, and a survey completed by maternity staff prior to our inspection showed 62% of staff felt safe to report concerns without fear of what would happen as a result.

Student nurses told us that the culture at ward level was good. Consultants interacted well with the students.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey prior to the inspection. The survey ran between 1 September and 15 September and there were 57 responses from maternity staff working at the PRH. In response to the question: I feel safe to report concerns without fear of what will happen as a result, 26% strongly agreed, 36% agreed, 10% neither agreed or disagreed, 8% disagreed and 17% strongly disagreed.

Displays in and around the unit were out of date. For example on the postnatal ward, friends and family test results were displayed from September 2020. Staff did not have the time to update displays due to low staffing levels and prioritising patient care.

The trust assured CQC it was addressing the culture concerns raised during the inspection.

Governance

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

The maternity service was part of the women's and children's division. Senior leaders described the ward to board communication as good. The triumvirate leadership team consisted of the chief of service, obstetric lead and head of mdwifery and reported to the chief nurse for the trust.

We saw that data pertaining to maternity was shared through the quality committee. Following the inspection, we were sent a Summary of Maternity Reports for Quality Committee document dated 28 September 2021. The report showed there were no moderate or severe harm incidents or avoidable perinatal deaths in August 2021.

The report acknowledged that staff have had to be pulled from skills drills training due to staffing concerns, however the report stated this had been minimised and based on current training status. However, the skills drills training rates were much worse than the trust target which indicates that this had not been fully considered. Training rates for staff on this site were not included, nor were vacancy rates or sickness rates. We noted that for other sites, this information was included on the report, and therefore key information regarding the site may not have been considered for this report. This meant there was lack of oversight at these meetings of the risks and performance at the Princess Royal Hospital.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey prior to the inspection. The survey ran between 1 September and 15 September and there were 57 responses from maternity staff working at the PRH. In response to the question: the team I work in often meets to discuss the team's effectiveness, nearly half of staff (49%) disagreed. 26% did not agree or disagree and 23% of staff agreed.

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

Management of risk, issues and performance

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

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

Risks were discussed at the monthly maternity Quality and Safety Meeting and were measured against the risk reckoner which was used by the trust to determine risk to patients, staff and the organisation. All recorded risks were reviewed by the divisional leadership team and reported by exception through the governance meeting structure.

The top three risks were unsafe staffing levels, community temporary premises and delays in care due to lack of antenatal clinic capacity. All three of these risks had actions listed to try and mitigate and manage the risks. However a risk described to us on site was not seen on the risk register provided. This meant that not all risks were captured on the risk register.

Maternity

University Hospitals Sussex engaged with the Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. They ensured they actioned HSIB recommendations. There are currently 19 cases with the HSIB. The majority of the referrals (55%) related to 'cooled' babies or those diagnosed with brain injuries. One of the recommendations for PRH was to ensure that there was consistent use of the fetal monitoring categorisation tool (including 'fresh eyes' review) and that all staff are supported to recognise CTG concerns.

Maternity performance was discussed at the trust board meetings. The last public board meeting occurred on the 5 August 2021. Minutes from the meeting showed the board the data in relation to serious Incidents, maternity dashboards and Ockenden recommendations was very reassuring. However, the information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure.

The service had electronic systems for collecting and analysing data. All areas had password protected computer terminals for staff to access information.

All computer terminals were password protected when not in use.

Data was not used to assess and improve performance. Staff told us they were not reporting all reportable incidents as they did not have time. Staff did not complete required incident reports where it was considered to be repeat information such as for staffing levels therefore reducing the reliability of the information for analysis.

Engagement

Leaders and staff actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. However some staff reported feeling detached from trust level changes.

Staff told us that whilst they were aware of the trust's recent merger, they did not feel part of the change or aware or what this meant for the future. Staff felt that there were a lot of emails sent which may have included key information, but they simply did not have time to check their emails on top of their daily clinical workload.

Whilst there were regular handover meetings where key safety messages were shared, staff rarely had the chance to meet as a unit. Staff told us that the Head of Midwifery set up an online meeting for everyone to attend, but that this happened a year into the pandemic and there had been nothing before this.

The service had developed the post of a communications midwife during the pandemic. The remit of this role was to use innovative ways to communicate with women and their families about the maternity service. They used a variety of social media platforms such as Facebook, Instagram, WhatsApp, and email to keep women updated.

The bereavement leads had established working links with the local Stillbirth and Neonatal Charity group and had developed a bereavement suite.

The maternity matters website signposted women to local groups such as National Childbirth Trust and support groups for vulnerable women. 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.

Maternity

Learning, continuous improvement and innovation

Staff were not always able to commit to continually learning and improving services. They did have a good understanding of quality improvement methods and the skills to use them but not the time to focus on quality improvement.

The trust had implemented the Patient First programme as a service improvement tool at the other trust sites and throughout some departments in PRH. However, staff we spoke with were not aware of this tool or any other improvement tools in use on the unit.

Staff spoke highly of the on site practice development team, and told us that if a staff member had the energy and capacity to take on additional learning they would be supported, however most staff 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:

The trust must ensure that

The service must ensure staff complete mandatory, safeguarding and any additional role specific training such as skills drill training, CTG training and competencies, in line with the trust target. (Regulation 18 (2) (a)).

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

The service must ensure policies and guidance are reviewed in a timely manner. (Regulation 12 (2) (b).

The trust must ensure that the service uses a systematic approach for risk assessing women attending triage. (Regulation 12 (1) (2) (a, b))..

Action the trust SHOULD take to improve:

The trust should ensure all clean equipment is labelled in line with trust policy.

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

The trust should ensure that cleaning records are kept up to date in all areas.

The trust should ensure that carbon monoxide screening is undertaken.

The trust should ensure that all incident investigation reports record the learning outcomes or whether feedback had been given to the reporter.

The trust should ensure that ward rounds are multidisciplinary.

Our inspection team

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