University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Inspection report

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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 Royal Sussex County Hospital

Inspected but not rated

We carried out this unannounced focused inspection of maternity and surgery 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 and surgery services across the hospital. 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 and surgery staff to give them opportunity to share their experience of working at Royal Sussex County Hospital and to raise and share concerns in a safe and confidential way. The staff survey for was open to staff from 01 to the 15 September 2021. The anonymous results and staff comments have been used as evidence to support our report.

We inspected surgery and maternity and focussed on the safety and well led key questions as the information about the safety and quality we received related to these key questions.

We rated both maternity and surgery as inadequate in both key questions.

Our rating of services went down. We rated them as inadequate because:

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

Infection prevention and control standards and practices were not consistently applied across some areas.

Staff did not have training in key skills. Not all staff were up to date with emergency life support training.

The service did not manage safety incidents well and did not always learn lessons from them.

Leaders did not run services well or support staff to develop their skills.

Staff did not understand the service's vision and values or how to apply them in their work.

Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities.

However:

Staff have a good understanding of their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area. However not all staff had up to date safeguarding training.

Medicines optimisation was managed safely.

Staff assessed risks to patients and acted on them

Our findings

Staff were focused on the needs of patients receiving care.

The service engaged well with service users and the community to plan and manage services.

Staff collected safety information.

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

During the inspection we spoke to 40 members of staff including maternity care assistants, administrators, nursery nurses, midwives, senior leaders, doctors and anaesthetists, health care assistants, medical students, doctors in training, nurses and allied health professionals. We attended four multidisciplinary meetings, reviewed 18 patients notes and ten prescription charts. We reviewed a variety of data and meeting minutes. Twenty staff have contacted the Care Quality Commission to share their views as they were not able to speak to us on the day of the inspection.

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.

Surgery

Inadequate ↓↓

We carried out this unannounced focused inspection of surgery 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 and surgery services across the hospital. 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 surgery staff an opportunity to share their experience of working at Royal Sussex County Hospital and to raise and share concerns in a safe and confidential way. The staff survey for was open to staff from 01 to the 15 September 2021. The anonymous results and staff comments have been used as evidence to support our report.

We inspected surgery and focussed on the safety and well led key questions as the information about the safety and quality we received related to these key questions.

We rated surgery as inadequate in both key questions.

Our rating of services went down. We rated them as inadequate because:

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

Infection prevention and control standards and practices were not consistently applied across some areas.

Staff did not have training in key skills. Not all staff were up to date with emergency life support training.

The service did not manage safety incidents well and did not always learn lessons from them.

Leaders did not run services well or support staff to develop their skills.

Staff did not understand the service's vision and values or how to apply them in their work.

Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities.

However:

Staff have a good understanding of their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area. However not all staff had up to date safeguarding training.

Medicines optimisation was managed safely.

Staff assessed risks to patients and acted on them

Staff were focused on the needs of patients receiving care.

The service engaged well with service users and the community to plan and manage services.

Surgery

Staff collected safety information.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not provide protected time for them to complete it. Completion of mandatory training was below the trust target for all staff groups except for administration staff. Staff did not have up to date training in life support.

The trust had nine mandatory training modules which included manual handling, health and safety and infection prevention and control. The trust target for completion of mandatory training was above 90%.

Data provided by the trust showed across the surgical wards; administration staff were 100% compliant, healthcare support staff were 77% compliant, nursing staff were 80% compliant and medical staff were 76% compliant. In the basic life support module healthcare support staff were 63% compliant, nursing staff were 66% compliant and medical staff were 43% compliant.

Data for staff working in neurosurgery theatres showed; administration staff were 63% compliant, healthcare support staff were 74% compliant, nursing and operating department practitioners' staff were 74% compliant and medical staff were 72% compliant. In the basic life support module healthcare staff were 33% compliant, nursing and operating department practitioners were 62% compliant and medical staff were 72% compliant.

Data for staff working in main theatres and recovery showed; administration staff were 81% compliant, healthcare support staff were 77% compliant, nursing and operating department practitioners were 80% compliant and medical staff were 79% compliant. In the basic life support module healthcare support staff were 47% compliant, nursing and operating department practitioners were 64% compliant and medical staff were 48% compliant.

Staff said they were not given protected time to complete mandatory training and when booked onto training this was often cancelled at the last minute as they needed to work clinically.

Not all staff felt that mandatory training was comprehensive and met the needs of patients and staff. Staff working in the recovery units did not complete additional mandatory training in caring for patients who would normally be cared for in a different area of the hospital. For example, patients from the emergency department or patients with critical care needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, they did not ensure they were given the time to complete it. Practice educators told us that they had escalated the issue to managers but due to clinical pressures teaching time was not ring fenced. For example, theatre staff were unable to attend protected monthly teaching sessions, due to being short staffed and operating theatre list overruns.

Surgery

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. Training records showed nurses were compliant with the trust target of 90% for both adult and children safeguarding training, doctors were not compliant with the trust target with either modules.

However, staff showed a good understanding of the trust's safeguarding policy and gave examples of when they had reported a safeguarding concern and were positive about the support they had received from the trust's safeguarding team.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, the equipment and the premises were visibly clean. Records showed that cleaning was undertaken in line with trust policies. However, infection prevention and control audits had not been undertaken in theatres to provide.

Staff cleaned equipment after patient contact but there was no evidence of what equipment had been cleaned. Only commodes had "I am clean stickers" showing the date that it was last cleaned.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). In theatres, some staff were not bare below the elbows and some staff were not wearing face masks correctly on ward areas. We observed some staff challenged colleagues who were non-compliant on this but not all.

Rooms had not been risk assessed for maximum occupancy to ensure social distancing was maintained.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. In theatres, storage was an issue and there were staff belongings such as bags and umbrellas within the operating theatre, this posed an infection risk as germs could be transferred to the theatre environment. Staff told us that storage of their belongings was an issue as their lockers were a distance away from the theatres in the staff changing rooms. Staff did not feel the changing rooms and lockers were secure.

Staff had easy access to PPE such as masks, face shields, gowns and gloves. There was also sufficient access to antibacterial hand gels, as well as handwashing and drying facilities.

One of the handwashing sinks in the anaesthetic room of theatre one was not compliant with national guidelines as it had an overflow and the tap was directly over the plug hole. There was another handwashing sink in the anaesthetic room which was complaint.

Patients underwent infection screening (such as Covid-19 and MRSA) prior to admission. Patient records confirmed this was undertaken. Patients identified with an infection were isolated in side-rooms. Appropriate signage was used to protect staff and patients.

Staff worked effectively to prevent, identify and treat surgical site infections. We observed antibiotic cover was discussed and administered to a patient in theatre. Staff could seek advice and support from the trust-wide infection prevention and control team.

There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Cleaning schedules were complete.

Cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly audits. These audits on wards showed good compliance. However, in theatres the audits had not been consistently undertaken and results were not acted upon. For example, hand hygiene audits had not been completed for four months out of the last six months and infection prevention weekly assurance audit results were below 96% for four of the last audits. The trust told us that if any audit findings were below 96% that remedial action and a re-audit was undertaken, but there was no evidence this had happened.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Not all staff were trained to use them. Staff managed clinical waste well.

The service did not have suitable facilities to meet the needs of patients' families. Some patients were kept in the recovery area for extended periods when a bed in the hospital, high dependency unit or intensive care unit was not available.

Theatres were meant to undertake monthly prothesis verification audits, to ensure the checking process was adhered to, this ensured the correct prothesis was implanted. This audit had been completed for four months out of the last six and the average compliance score was 75%. All audit results were below 95% which was meant to prompt action to be taken and a re-audit undertaken, but there was no evidence this had happened. This meant that the service could not be assured that the correct checks were being completed to ensure the correct prothesis was implanted into a patient. A prosthesis is a device designed to replace a missing part of the body or to make a part of the body work better.

Surgical count audits were meant to be undertaken in theatres to ensure every item was accounted for in an operation. However, these had not been completed for four months out of the last six months.

Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys had tamper evident tags. The contents of the trolleys were checked in line with trust policy and records were complete. The only exception to this was on Gastro level 9 ward where one of the resuscitation trolleys had not been checked on 10 occasions in a four-week period. Staff told us that there was confusion over who had responsibility for checking the trolley, the other trolley on the ward had been checked daily consistently. We found emergency equipment was fit for use. After the inspection the trust provided CQC with assurance all equipment was now checked in line with trust policy.

Staff carried out daily safety checks of specialist equipment. Records confirmed anaesthetic equipment was available and fit for purpose and checked in line with professional guidance.

Surgery

Equipment was serviced by the trust's maintenance team using a planned preventive maintenance schedule. All equipment had a sticker indicating when it last underwent an electrical safety test, so staff knew it was safe to use. However, the defibrillator on the resuscitation trolley on Gastro level 9 ward, the due date of the next test was March 2021. The trust provided additional assurance the defibrillator was checked and added to the routine maintenance schedule.

Due to the complexity of operations performed, highly specialised equipment was used. Theatre staff told us that due to being short staffed and experienced staff leaving there were not enough staff trained and competent to use the equipment. Staff gave us examples of near misses involving equipment. In addition, staff told us of an incident involving the incorrect use of a surgical instrument resulting in injury to the patient.

We reviewed the patient safety incident investigation report for an incident involving a piece of equipment called a dermatome which resulted in an injury to a patient. A dermatome is an air-powered surgical skin grafting instrument, with an adjustable depth gauge which takes skin grafts. The blade on the dermatome was assembled incorrectly which resulted in two full thickness grafts instead of partial thickness these then required treatment. The investigation did not find the reason why it was assembled incorrectly by staff. In response to the incident the service had developed a dermatome checklist, for staff to follow to ensure it was assembled correctly.

Storage areas and corridors in theatres were cluttered, and staff told us there was a shortage of storage space. Theatre doors with signs on stating do not block doors were blocked with theatre equipment. However, there was an effective system for safe storage of consumables and surgical implants.

There was no clear signage to indicate the maximum person occupancy of rooms to ensure compliance with social distancing rules within a healthcare facility.

Fire safety was not always managed safely. On 8A East ward we saw a fire extinguisher stored on the floor and fire doors that were to be kept locked were open and vice versa.

There were effective arrangements for the safe handling, storage and disposal of clinical waste, including sharps.

Data showed that between July 2021 and September 2021, 168 patients spent more than one hour in recovery awaiting a bed in the hospital. Patients were delayed in recovery ranging from 41 minutes to 41 hours. This meant patients did not have their privacy when they needed it, did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, staff without the necessary skills, competence and training were caring for patients. Patients requiring surgery experienced delays and cancellations placing them at risk of deterioration.

Due to capacity and flow issues within the hospital patients requiring either a high dependency, intensive care or a ward bed spent prolonged periods of time in recovery. This impacted on the department's ability to maintain flow and staff, without the required skills, knowledge and competence, cared for patients. In addition, staff also undertook aspects of care normally outside of their role, meaning they may not be familiar with risks assessments, policies and procedures. For example, theatre staff and anaesthetists cared for recovering patients in theatres as the recovery area was full.

Surgery

The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services for Postoperative Care 2019 states: “When critically ill patients are held in the recovery area because of a lack of availability of appropriate facilities elsewhere, this should only occur if recovery staff are appropriately trained, and the recovery area is appropriately equipped to enable monitoring and treatment to the standard of a level 3 critical care unit”. Not all staff were appropriately trained in line with these guidelines. However, the recovery area was appropriately equipped.

Staff working in the recovery area were highly trained in looking after patients recovering from an operation, however they were not trained to look after high dependency patients, ventilated patients and patients transferred from the emergency department to the recovery unit.

Data showed between July 2021 and September 2021 a total of 40 patients requiring high dependency care were cared for in recovery, of these 25 patients spent more than three hours in recovery. In the same time period 25 patients requiring intensive care were cared for in recovery, of these 20 spent more than three hours in recovery. In addition, in July and September four medical patients were cared for in recovery.

The trust told us that if a post-operative patient was too ill to return to a ward and there was no high dependency or intensive care bed then they remained in recovery as this was the safest place for them. When this occurred the intensive care unit nursing team and the anaesthetic consultants assisted with care. However, staff and the directorate leadership told us that this was not always possible, due to challenges in intensive care.

We reviewed an incident form completed in April 2021, in relation to patients requiring high dependency care, being cared for in recovery. On the day the recovery unit was full and included four patients who required high dependency care one of these patients deteriorated and required intensive care. Concerns within the incident related to not being able to keep up with all the care patients needed and although some support was provided by an advanced care practitioner and anaesthetist staff did not always feel supported. The incident was not investigated by managers until 12 October 2021 we were not assured that the actions recorded, or the time taken to investigate the incident reduced the risk of further similar incidents. The only recorded action was that staffing concerns were being managed through the directorate and divisional recruitment programme. The trust also provided a narrative for this incident and stated that the care and supervision of a significantly complex post-operative recovery period was appropriate.

Staff in theatres told us due to staff shortages they didn’t always have the ability to respond to patients who required emergency lifesaving surgery. The trust told us that due to shortages of staff and over-running theatre lists there had been occasions where between 6pm-9pm there was a shortage of staff to manage emergencies which required immediate surgery.

Patients requiring emergency trauma surgery that experienced delays were at risk of further complications from their injury. On the day of our inspection 34 patients required emergency trauma surgery, who were either at home waiting or were an inpatient. There were 18 patients admitted to the hospital waiting for emergency surgery. The longest wait for surgery was 16 days and the patient’s operation had been cancelled three times, other inpatients had waited between 15 days and one day. Of the patients waiting at home for surgery the longest a patient had waited was 20 days. Of all patients five had been cancelled five times, three patients had been cancelled three times and two had been cancelled twice.

Surgery

Patients requiring general emergency surgery experienced delays and were at risk of their condition getting worse. Between 31 August and 28 September 2021, 76 patients were booked to have emergency surgery of these 45% had their surgery postponed. The most common reason for postponement (64% of all) was more urgent case added. Of the 76 patients, two had been waiting seven days, two had waited six days, two had waited five days, four had waited four days, eleven had waited three days, 18 had waited two days and the remainder had waited one day.

Between January 2021 and June 2021 there were 49 high risk patients needing an emergency laparotomy (a type of open surgery of the abdomen to examine the abdominal organs).Of these 96% had consultant surgeon and consultant anaesthetist who delivered care, 100% of had a consultant surgeon operating, 96% of patients had consultant anaesthetist presence. This was in line with National Emergency Laparotomy Audit guidelines.

Between the 01 July and 01 October 2021, September, a total of 113 patients had their elective operations cancelled on the day, four patients had been cancelled twice and one patient had been cancelled four times. Of these, the most common reason (41%) for cancellation was no intensive care or high dependency bed.

Theatre staff told us they were often allocated as part of the staffing of a theatre whilst carrying an emergency bleep, therefore they were unable to respond to other clinical emergencies in the hospital.

Staff undertook the World Health Organisations (WHO) '5 steps to safer surgery' checklist in theatres and undertook audits to measure compliance. We saw staff consistently undertaking all five steps of the checklist. However, observational WHO audits were meant to be completed every month but had not been completed for four months out of the last six months. This meant the service could not be assured that WHO processes were adhered to.

A manager told us that compliance was poor with the debrief step as staff had to return the WHO debrief document at the end of the day to be included in the audit. If staff did not return the form, then it was assumed it was not done.

Staff understood how to identify the signs of sepsis and the management of sepsis in line with national guidelines. Patient records showed they received appropriate care and treatment for sepsis.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks were consistently completed.

Safety huddles were undertaken in theatres and on the wards. Patient safety issues were discussed, and action taken to mitigate the risks. For example, communicating patients at risk of falls. A 'wrap up' ward round was undertaken at 4pm, to ensure any patients who may be deteriorating were identified.

Staff used the national early warning score systems (NEWS2) tool and regular monitoring based on patients' individual needs to ensure any changes to their condition was promptly identified.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a handover which was comprehensive and identified any risks and patients at risk of deterioration.

Nurse staffing

Surgery

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and tried to adjust staffing levels and skill mix however, it was not always possible to ensure that the number of staff and skill mix was safe. The service had high turnover and vacancy rates. Bank and agency staff had a full induction.

Theatres and recovery did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. All staff in theatres and recovery spoke of poor staffing and exhaustion.

Several staff members mentioned the department sometimes felt unsafe due to staffing numbers, skill mix and the acuity of patients. Staff had been going above and beyond to work in extremely challenging circumstances. Due to ongoing pressures and lack of clear leadership across the department, this had left many staff exhausted and several had left as a result.

Data showed within main theatres and recovery there was a vacancy of just over 20 whole time equivalent (WTE) staff. The highest vacancy was amongst qualified nurses/ nurse managers which was nearly 18 WTE staff. The overall vacancy rate was just over 13%, for qualified nurses/ nurse managers the vacancy rate was nearly 26%. The trust told us that as part of the international recruitment programme 15 WTE conditional offers had been made.

Data showed across the surgical wards there was a vacancy of nearly seven WTE staff. All but half a WTE were within qualified nurses.

Data showed the average vacancy rate amongst all staff groups in neurosurgery was 15%. The highest vacancy rate was 35% (10 WTE) amongst nursing staff in neurosurgery theatres.

Data showed the average staff turnover rate in the surgery division was 10%. The highest turnover rate was 22% amongst nursing staff in main theatres and the lowest was amongst administration staff (no turnover of staff). The average staff turnover rate in neurosurgery was 7%. The highest turnover rate was 12% amongst nursing staff in neurosurgery theatres and the lowest was amongst administration staff (no turnover of staff).

Recovery staff were caring for patients who required either high dependency or intensive care or had been transferred from the emergency department. Theatre staff were recovering patients in theatres, when recovery was full, they may not be familiar with recovery processes or policies.

The trust told us that every morning each operating theatre team conducted a safety huddle which involved all the theatre staff and was used to discuss: the trust's message of the week, the day's planned operating, resolve any problems/issues for example patient flow, resolve any staffing/skill mix issues and any safety issues. However, we saw on inspection that it was not always possible to resolve these issues and staff told us that they had raised patient safety concerns, and these had not been acted upon.

Managers in theatres and recovery could not always adjust staffing levels daily according to the needs of patients. Although daily staffing levels were calculated based on expected theatres lists; staff sickness, bed vacancies, emergency attendances and patients requiring intensive and high dependency care attendances, currently could not be met with the staff available.

Surgery

The leadership team acknowledged significant challenges with staffing in theatres and this made it difficult to complete a rota which was balanced with staff who had the right skills and experience. The high vacancy rate also impacted for the flow of patients through theatres and recovery.

During August, September and up until the trust provide the data for October 2021, there were 56 incidents reported by staff regarding staff shortages in theatres and recovery.

Theatre staff told us that operating lists went ahead when staffing was below national guidelines, such as the Association of Perioperative Practice (AfPP) guidelines. Data provided to us by the trust showed that between April and September 2021 there were 406 theatre sessions that were undertaken with staffing below AfPP guidelines.

The directorate leadership team told us that a risk assessment was undertaken before allowing a theatre list to go ahead without staffing that was in line with national guidance. However, were not able to evidence that these risk assessments were undertaken and said it would be discussed at the World Health Organisation (WHO) five steps to safer surgery briefing, but audit data for WHO briefings showed low compliance, so this did not provide assurance that the risk assessments were completed

The directorate leadership team had reduced the theatre activity to try and ensure theatres were covered by a safe level of staff. However, the staffing was still insufficient to cover the planned theatres sessions safely. During the inspection an elective list was cancelled due to a lack of theatre staff, we saw that the chief of service made a clinical decision in consultation with their colleagues on which an operating list was cancelled.

Staff told us that a lack of staffing was particularly a problem during weekends and nights. Staff covering the evening shift for emergency operations were often used to take over from the day stay when elective procedures overran. This meant there was not adequate staffing to respond to patients requiring emergency surgery.

Staff told us that the leadership team had tried to mitigate the risk during nights by having staff on call from home, but staff felt this did not help and more staff on the shifts was needed. The trust told us that there was always either a qualified nurse of Operating Department Practitioner on call out of hours but there was not agreed response times from being called in and arriving in the department. Between April and September 2021 staff have been called in on 11 occasions. The trust told us that there was also a senior member of staff on call in the event of a major incident.

Staff working in the neurosurgery theatres told us that they often had to work a shift the following day when they had been resident on call and may have been working through the night. Data provided to us by the trust showed that between April 2021 and September 2021, 23 staff had worked a day shift after working in the night during whilst resident on call.

Data provided to us by the trust showed that between April 2021 and September 2021, 79% of planned day time emergency surgery operating lists were actually undertaken. In the same time period 96% of planned day time trauma operating lists were actually undertaken.

The directorate leadership team told us that a successful international recruitment programme meant that the staffing issues in theatres would be improved, this relied on there being enough suitable staff to provide training and a period of consolidation for the new staff.

Surgery

The trust told us that safety was assessed and monitored when carrying out changes to the service or the staff. For example, a recent local consultation processes, involved the temporary redeployment of the day surgery staff, Hurstwood Park Ward and Sussex Orthopaedic Treatment Centre staff to support other areas within the perioperative directorate as a result of the Covid-19 pandemic. This involved group and team discussions and 1:1 sessions with staff involved. This consultation process aligned with the Trust Policy Managing Organisational Change.

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

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Data showed there were no consultant surgeon or anaesthetist vacancies. There were just over 14 WTE surgical trainee doctor vacancies, this was a vacancy rate of 30.5%. The highest vacancy rate was 25% within Specialty Registrar doctors who had completed three or more years of their specialist training.

Health Education England, had ongoing concerns regarding the supervision, support and workload of junior doctors on the general surgery rotation and were closely monitoring the action plan developed by the trust in response to the concerns raised.

Junior doctors told us that their workloads in the daytime were not achievable and they often stayed after their shift had finished to complete tasks.

We reviewed the Guardian of Safe Working Hours Quarterly Report covering October 2020 to December 2020 for general surgery at this hospital. The report showed there were 38 exception reports; all cited late finishes as the reason for submission. The common theme was ward was busy with lots of high acuity patients. Trauma and orthopaedics had 13 exception reports five were due to missed educational opportunities, particularly missing scheduled theatre lists or trauma theatre lists because of being re-allocated to ward cover. The other eight reports related to busy ward workload and reduced staffing leading to late stays.

The service did not always have a good skill mix of medical staff on each shift. Senior support during nights and weekends were of particular concern especially if the senior staff were in theatres, this left junior doctors in charge of patients when they may not have the experience or competence to care for patients if they deteriorated. The trust had a number of plans to address these concerns and Health Education England was monitoring this closely.

Data provided by the trust showed that between 04 August 2021 and 12 October 2021 there were 13-night shifts that did not have a foundation (junior doctor) surgery doctor. Of these 10 were covered by locum doctors, three were covered by the more senior doctors in training that were on the night shift. This meant if the two more senior doctors were busy in theatres or responding to emergencies, there may not be adequate support for patients on the surgical wards.

The trust had introduced some additional roles to reduce the burden on general surgical junior doctors and to increase support and supervision. A prescribing pharmacist had been employed to assist with prescribing medicines and to offer support and guidance to junior doctors involving medicines. Additional locum middle grade doctors had been employed to provide support and supervision for junior doctors at night and at weekends. The locum middle grade doctors were due to commence employment in November 2021.

Surgery

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 63 responses from staff working in general surgery at the hospital and included 24 comments from staff. Some of these comments were from junior doctors and included "juniors are not valued", "consultant politics passed on to juniors" and "bad leadership, bullying, undermining".

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, patient record audit findings showed mix compliance.

Patient notes were comprehensive. Staff recorded the necessary information. We reviewed eight patient records, and all had dates, times or notes about patients' preferences or wishes. Staff could find the most up-to-date information about patients when they needed it.

Patient records were mainly paper based. Patient records were stored securely in locked trolleys. When patients transferred to a new team, there were no delays in staff accessing their records.

Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis in line with trust policy. Care plans were person-centred.

The service used a software system to collect data to measure compliance on a variety of different audits, including documentation. Between July and September 2021 documentation audits showed compliance between 97% (ophthalmology) and 74% (L9A ward). There were three different wards and departments when the audits were not completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always accessible for patients in recovery.

Recovery did not keep medicines that were needed to meet the needs of patients. Therefore, staff had to borrow them from wards. This may lead to a delay in patients receiving time essential and critical medicines. The service was working with the pharmacy team to improve the supply of medicines for patients who may have extended stays in the recovery area.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw safety alerts were displayed throughout to inform staff of any medicine recalls.

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. Controlled drugs stock levels were correct and the controlled drug registers were completed correctly.

The trust pharmacy department supplied medicines as stock to wards and departments. Medicines were stored securely and within their recommended temperature ranges.

Surgery

Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were fully completed including any allergies to medicines. However, medicine safety audits in theatres had only been completed for four months out of the last six and the average audit score was 75%. This meant that remedial action and a re-audit was meant to be undertaken and the service could not be assured that medicines were being handles safely in theatres.

Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antibiotics to identify and minimise the incidence of prescribing errors.

Incidents

The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses. However, managers did not investigate incidents and therefore lessons learned were not shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. However, staff said they did not always get feedback on incidents and did not feel listened to when they raised concerns. Information about incidents was not shared with others to promote learning, including those that have potential for harm. Investigation reports we reviewed showed that patients were invited to contribute to the investigation, were supported and apologised to.

Managers did not review and investigate incidents in a timely manner. At the time of the inspection there were 128 incidents within the service that had not been reviewed and investigated by managers. Of these, the majority were reported in theatres (62%) and recovery (22%). Forty four percent of all incidents reported related to short staffing in theatres and recovery.

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 63 responses from staff working in general surgery at the hospital and included 24 comments from staff. Comments from staff reflected a poor incident reporting culture and lack of feedback on incidents reported. Comments from staff included; that if staff report an incident, managers did not discuss it with them but then they receive an email to say they have been offered support when they had not.

The same online survey asked staff to rate and give feedback regarding how incidents were managed within the organisation.

In response to the question: I hear about incidents that happen in my part of the organisation and the learning from them, 17% strongly agreed,33% agreed,21% neither agreed or disagreed,16% disagreed and 13% strongly disagreed.

In response to the question: My organisation encourages us to report errors, near misses or incidents, 43% strongly agreed, 32% agreed, 6% neither agreed or disagreed,10% disagreed and 9% 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, 24% strongly agreed,30% agreed,16% neither agreed or disagreed,14% disagreed and 16% strongly disagreed.

Surgery

The service had one never event in surgery at this hospital which happened in the Sussex Eye Hospital in April 2021.We were told that not all staff had undertaken training in how to investigate never events or incidents. However, the directorate risk and governance team were able to provide support and guidance.

We reviewed the patient safety incident investigation (PSII) report of the never event, which identified contributory factors. It could not be confirmed that staff had all received and read the most recently updated guidelines, and staff were unable to recall when they had last received training specifically on prosthesis verification. The investigation also revealed that staff working in the Sussex Eye Hospital were unable to attend quality and safety education sessions, not all staff were aware how to report an incident and did not follow national and trust guidelines. We were not assured that managers shared learning about never events with their staff and across the trust. The PSII report stated that action plans received oversight from the trust evidence of improvement panel and the trust patient safety group. However, it was not clear how learning from the never event would be shared with staff or how any changes of practice would be communicated to staff.

Staff mainly reported serious incidents clearly and in line with trust policy. The only exception of this was staff reporting the never event, they did not report it until five days after it occurred. The investigation found that staff were uncertain about whether the incident met the criteria for a never event and not all staff were comfortable with the incident reporting system.

The two investigation reports we reviewed did not assign individuals to actions or include time frames for when the actions should be completed, meaning actions may not be completed. Although the trust told us that action plans received oversight from the trust evidence of improvement panel and the trust patient safety group. It was not clear how actions were monitored at local level.

Staff did not always meet to discuss the feedback and look at improvements to patient care. Operational pressures and short staffing in theatres meant department meetings were not effective in supporting lessons learnt and improving patient care. However, surgical wards had daily safety huddles where incidents and learning were discussed. We saw an example which confirmed this occurred.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. However, the service did not collect data on catheter acquired urinary tract infections.

Safety thermometer data was displayed on wards for staff and patients to see.

Between April and September 2021, there was 38 reported falls across wards and departments at the hospital. One fall resulted in moderate harm and occurred on Level 11 West (orthopaedics) in April, no other falls resulting in moderate harm have occurred since. The rolling average falls rate (per 1000 bed days) was 3.16 which was below the trust average of 3.60 falls per 100 bed days and the national average of 6.63.

In the same time frame, there was 55 acquired pressure damage and eight venous thromboembolisms recorded on the trust's incident reporting system.

In the same time frame, 55 reports of acquired pressure damage and eight venous thromboembolisms were recorded on the trust's incident reporting system.

Surgery

Staff used the safety thermometer data to further improve services. For example, there was a focus on reducing patient falls.

Is the service well-led?

Inadequate ↓↓

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

Leadership

Not all leaders had the skills and ability to run the service. They did not fully understand and manage the priorities and issues the service faced. However, this was improving. Staff did not feel all leaders were visible and approachable in the service for patients and staff. Staff did not feel supported to develop their skills and take on more senior roles.

The perioperative directorate is part of the surgical division. The perioperative directorate was led by chief of service, divisional director of operations and divisional nurse lead (current post holder was acting). This leadership style is referred to as a triumvirate. The triumvirate were responsible for perioperative care at; theatres level five and Sussex Eye hospital at the Royal Sussex County hospital site, Princess Royal hospital, Lewes Victoria hospital and the Sussex Orthopaedic Treatment Centre. The triumvirate were supported by a clinical director, a directorate manager and directorate lead nurse (current post holder was acting). In addition, there were 14 band sevens and two theatre managers. Neurosurgery theatres sat within the specialist division which had a similar leadership structure. The surgical wards and departments sat within the surgery division and abdominal surgery and medicine directorate, which had the same triumvirate leadership structure.

Members of the perioperative triumvirate had clear roles and responsibilities, but we were not assured they had a clear oversight or understanding of challenges that staff faced, performance, risk, governance and culture especially within theatres and recovery. However, following the listening event held with theatre and recovery the triumvirate acknowledged that decisive and urgent action was needed and had developed an action plan which was achievable, with some actions to reduce the burden on staff were made and implemented quickly. Other aspects such as changing culture and re-establishing governance process would take longer to change and embed which they acknowledged.

Each surgical speciality had a clinical director and a matron who was supported by the ward managers.

There was disparity between what the executive team and the triumvirate leadership team were doing to engage with staff and how that was perceived by staff working in theatres and recovery. Ward staff said they considered local leadership and management teams to be accessible, responsive and supportive, most staff said they rarely saw senior staff above matron level. Leaders did not manage the priorities in a way which reduced pressure and assisted staff treating patients within theatres and recovery.

Staff had mixed views regarding the visibility, how approachable trust leaders were, and the transparency of processes followed by leaders. Theatre and recovery staff told us that they had not ever seen a member of the executive team in the department.

Surgery

Staff had raised concerns regarding the precarious staffing situation in theatres, managers had not acted on these concerns and had not reviewed incidents relating to patient safety raised by staff. There was no tangible evidence that managers understood until recently the risks, culture, leadership and morale in theatres and recovery.

Staff did not feel supported to develop their skills and take on more senior roles. Theatre and recovery staff told us that due to staff shortages there was no dedicated time to undertake aspects of their role and for teaching and learning. Band six and seven staff in theatres and recovery did not have time to perform appraisals for junior staff or line management responsibilities.

Theatres and recovery had a historical issue of interim leaders which did not provide the stability and oversight required. Leaders in theatres were not supported to run the department, due to the staffing shortages they spent the majority of their time firefighting to keep the service running. Not all theatre and recovery staff felt that leaders had the skills and ability to run the service.

The perioperative leadership team, supported by human resources and the trust's Patient First Improvement System team, held a listening event with recovery and theatre staff in September 2021. The leadership team told us the meeting had given them a better understanding into the risks, challenges and concerns that staff had. As a result, they had developed an action plan to address the issues raised.

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

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action but were not able to achieve it due to staff shortages and lack of high dependency and intensive care capacity. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The vision and strategy for the surgical division, of which perioperative services form a significant part, is embedded in the trust's overall vision and strategy – Patient First. Patient First sets out the trust's overall vision and describes the trust's strategic framework across its strategic domains – patient, people, quality, sustainability, and systems and partnerships.

Staff told us they did not feel engaged with the Patient First Improvement System and felt there was a disconnect between local staff experience and the understanding of divisional leadership and above.

The trust's clinical strategy (Brighton and Sussex University Hospitals 2019 to 2024) set out the trust's overall approach. Within this, the key priorities and decisions for the surgical division, and more specifically for perioperative services. The clinical strategy highlighted the following priorities; development of capability for a surgical robot, centralising theatre management and improvements in efficiency, modernisation of preoperative services and the development of a urology investigation unit at Princess Royal Hospital.

In May 2020, the trust board approved a new clinical strategy framework for the merged organisation. The development and delivery of the new clinical strategy was overseen by the trust's quality committee. Within this, perioperative services were seen as critical to delivering the trust's overall clinical strategy. Alongside all other services within the trust, perioperative services will be developing its own 'Mission Statement' which will capture the key strategic issues and risks facing the service and set out the priorities for the next three years.

Surgery

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care but were not always able to deliver the level of care they needed. The service was not able to demonstrate that it promoted equality and diversity in daily work and provided opportunities for career development. Staff did not feel the service had an open culture where patients, their families and staff could raise concerns without fear.

Low morale and perceived bullying and harassment was reported from some groups in theatres and recovery including at managerial level. Staff did not always recognise the leadership team as dealing with their concerns around these matters. There were some staff who did not feel able to express their concerns or speak up for fear of reprisal.

There was a mixed perspective from staff regarding feeling respected, supported and valued, including the actions taken as a result of raising concerns.

After listening to staff about their experiences working in main theatres and recovery, we had concerns about the culture amongst colleagues. We were given an examples of inappropriate behaviour between colleagues which indicated a toxic culture.

In the same CQC survey mentioned previously in the report. Of all the 24 comments received, there was only one positive comment about the service. Comments from staff on culture included: “A very hostile department to work in”, “problems are resolved in a disciplinary manner rather than an opportunity for change” and “improvement, bullying complaints are dismissed, juniors are not valued” and “a toxic culture of intimidation and bullying has been created”. Of the 24 comments 10 mentioned a poor reporting culture, failure of leaders to follow up on concerns raised or bullying and harassment.

Theatre and recovery staff felt the executive team did not understand the pressures they experienced in the department. We found evidence of strained relationships between theatre and recovery staff and local leaders.

Whilst the trust undertook a variety of events and initiatives to support the well-being of staff, theatre staff and recovery staff were not able to access these. The triumvirate leadership team recognised that they needed to find alternative ways of supporting this staff group’s welfare.

Patients having to wait longer for emergency operations, cancelling patients and staff shortages had a negative effect on staff morale. Staff in theatres and recovery told us that staff morale had never been as low.

The trust had a part time Freedom to Speak Up Guardian, there were no Freedom to Speak Up champions. Staff told us they didn’t know who the Freedom to Speak Up Guardian was or how to contact them, as there was no information available. We did not see any information informing staff of who the Freedom to Speak Up Guardian was or how to contact them.

The hospital had a Workforce Race Equality Standard action plan which was developed in 2018 and was due to cover the time period between 2018 until 2021. The plan had 12 actions, of these six had been completed, the rest had not been updated to indicate if they had been completed or were still in progress.

Surgery

The trust's Workforce Race Equality Standard 2021 data suggested that white candidates were more likely than black minority and ethnic candidates to be appointed from shortlisting. The data also suggests that black minority and ethnic staff members were less likely than white staff to enter into a formal disciplinary process. Compared to the previous year, trust staff saw an increase (and white staff a slight decrease) in stating they have experienced discrimination from their manager/team leader or other colleagues.

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

Governance

Local, triumvirate and trust wide governance was not clear. Not all staff were clear about their roles and accountabilities. Due to staffing issues within recovery and theatres staff were undertaking additional roles.

Each surgical speciality undertook monthly mortality and morbidity meetings. We reviewed a selection of the presentations and meeting minutes from these which showed good attendance and any actions to take forward. All had any learning identified and actions had a person assigned to them. This was in line with the Royal College of Surgeons guidelines.

We reviewed three theatre and recovery audit meeting minutes, these did not follow a set agenda, include risks, learning from incidents and didn't always record who attended the session. This did not provide assurance that these meetings were effective and kept staff informed.

The trust told us that monthly quality and safety meetings for the surgery division were undertaken whereby representatives from all specialities and areas within division would meet. We requested minutes for these meetings from the trust, but we were provided with different meeting minutes. We also requested governance meeting minutes, but these were not provided.

The trust told us that the issues we found in recovery and theatres were discussed at monthly quality and safety meetings, but we were unable to confirm this. Therefore, we were not assured the local departmental risks and concerns were effectively escalated up to and including board level.

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 use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify effective actions to reduce their impact. They had no plans to cope with unexpected events. Staff reported a lack of oversight and collaborative working from trust wide leadership.

The system to manage, identify, document and understand risk did not capture clinical and patient risks.

We reviewed the risk register which included eight risks across surgery, five risks had the same risk score which was the highest and all related to equipment. The delays in patients leaving recovery leading to poor patient experience was also on the risk register but with a lower risk rating.

The description of the risk included; inappropriately skilled staff dangerous staffing ratios for critical care patients and reduction in productivity through theatres, leading to delays and cancellations of patients' surgery. This risk had been

reviewed twice, in April 2021 and on the 30 September 2021 (two days after our inspection) The most recent update stated the use of recovery continues to be monitored and reported upon, however no overall improvement. The control measures in place were not effective in reducing the risk and this was recorded on the risk register. The leadership team told us that there was an arrangement for support to be provided by anaesthetists and staff from the intensive care unit, however, this was not included as a control measure. Control measures and risks had staff assigned to them.

The risk register included comments that risks were discussed at quality and safety meetings, however we were unable to confirm this as the meeting minutes were not provided to us, meaning we had limited assurance that the risks we identified were known by the division leaders and the executive team.

Leaders did not always identify and escalate relevant risks and issues. The short staffing in theatres was not on the risk register at the time of our inspection. A manager told us that they had recently added it, although they had not received training in the process for adding risks to the register. Since our inspection the risk of delayed emergency and cancelled elective surgery due to staffing had been approved and added to the risk register. The adequacy of control measures were recorded as inadequate on the risk register.

We found some local risks were not recognised outside of the department. For example, poor infection prevention and control practices in theatres had not been identified and action taken.

Staff told us they felt pressured into caring for patients in recovery who had higher dependency care needs. Staff felt this would heighten patient safety risks and promote unsafe practice.

The trust told us that the recovery area was an escalation area within the hospital as this was a safer place for patients requiring a higher level of care. However, staff were not aware that this was an escalation area. We requested a copy of the hospital escalation policy however, an escalation policy for junior doctors was supplied. The trust later provided a copy of the full capacity protocol however, this did not mention theatres or recovery and was focussed on the emergency departments.

After the inspection, the trust told us to support the pressures on recovery one of the key actions in the theatre improvement plan was to construct and agree a robust standard operating procedure for the use of recovery and escalation about concerns with patients remaining in recovery. This was to provide the team with a clear process for escalation of concerns, and a policy which provided support when there were intensive care patients or ward patients remaining in recovery post-operation that were unable to be moved in a timely fashion. The timeline for completion was 15 November and involved agreement across the organisation, including theatres, intensive care, and the site management team who were all engaged in the process.

The trust said all the recovery team had either completed recovery competencies or were in the process of completing them. Not all staff had undertaken critical care courses, and they did not all have relevant intensive care experience. Trust data showed 25% of recovery staff had undertaken the relevant care of the critically ill training. Staffing allocations were reviewed as part of normal daily processes to try and ensure the skill mix was balanced and appropriate on each shift. Daytime shifts had a co-ordinator who supported junior staff in training. Recovery staff told us that they felt unsupported and at times had to prioritise the sickest patients, which meant they may not identify a patient who was at risk of deterioration.

The trust said to support the staffing shortages theatre sessions had been reduced by seven theatre sessions per week to free up skilled staff for redeployment and support. Staff did not think this was sufficient to be able to meet the needs of patients and be able to provide an emergency and trauma service. Elective lists were routinely cancelled and patients requiring emergency or trauma surgery experienced delays.

The trust told us that the anaesthetic rota had been amended to ensure more doctors were on call each day to offer additional support to the intensive care unit and recovery if needed. Recovery staff told us that if they required support from the intensive care unit on a particular aspect of a patient's care then intensive care nurses would support them, but they would not routinely be present in recovery providing support as they were also challenged staffing wise.

The trust told us that surgical cases were prioritised on the basis of the nationally recognised 'P' rating system and all emergency cases rated more highly on this system than elective cases. The current situation was more difficult than at the height of the Covid-19 surge and had resulted in the postponement of elective cancer cases recently because of intensive care bed availability and theatre staff shortages.

Consultants had raised concerns regarding the ability to be able to treat patients requiring emergency surgery and felt they were not listened to or their concerns were not taken seriously.

Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care. Theatre and recovery staff felt there was no collaborative working to optimise flow, which would lead to major, improvements in patient and service user experience and outcomes.

The service regularly reviewed the Covid-19 recovery dashboard at divisional safety and quality committees. Progress against a variety of metrics were reviewed monthly which included; cancer referrals, day surgery cases performed, elective cases performed and new referrals against the service's recovery plan.

Theatres and recovery were not able to demonstrate how it was performing in key audits as the majority had not been undertaken in the last six months, audits that had been completed showed a requirement for remedial action and re audit but this had not been undertaken.

Information Management

The service collected data and but did not always analyse and act on it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The hospital used a cloud based real time inspection and reporting tool for healthcare quality inspections. This eliminated administration by capturing inspection results directly onto mobile electronic devices which provided automated reporting.

It was launched in October 2020 and initially focussed on five inspections undertaken across all wards and departments on a five-weekly rotation. It included inspections on documentation, medicine safety, patient experience, staff and environment. In Spring 2021, two further inspections were added which were weekly infection prevention and control

assurance (weekly) and hand hygiene (monthly). In addition, at the same time theatres also added some inspections and audits to provide assurance on a number of specific theatre standards. These included; perioperative care metrics (monthly), prosthesis verification (monthly), count policy (monthly) and World Health Organisation 5 steps to safer surgery observation (monthly).

Between April 2021 and September 2021 main theatre and recovery had an overall compliance rate of 62% in terms of undertaking the audits as per agreed schedule of submission.

Engagement

Leaders and staff engaged with patients to plan and manage services. Public engagement was hospital wide, rather than locally facilitated. Staff did not feel included or engaged with decisions made by senior leadership.

Staff used a closed social media platform to share information and make requests such as shift swaps.

Not all staff received good support and regular communication from their line managers. Department and team meetings had been impacted by the pandemic and operational pressures particularly in theatres and recovery. Ward staff told us there was good support and regular communication with line managers.

The trust engaged with staff through newsletters and staff briefings from the trust's executive team. Other general information and correspondence was displayed on notice boards.

As part of the pandemic responses to the first and second wave Covid-19 surges, all internal business meetings were stood down. This included staff meeting in theatres and recovery and therefore opportunities for managers to engage with staff and to fully understand their concerns may have been missed.

The perioperative leadership team spoke clearly about compassion for the wellbeing of staff and the need to be inclusive, empathic and compassionate. The wellbeing of staff in theatres and recovery was a focus in the action plan to address concerns raised by theatre and recovery staff.

The senior leadership team had developed an action plan to address concerns raised by recovery and theatre staff following a recent listening event. The action plan focussed on workforce, wellbeing, values, behaviours, safety, skill mix, theatre utilisation and flow. There were 28 actions and 20 of these had been completed or started, each action had a person responsible for the action and time frames for completion. The actions reflected many areas that we found that needed improvement, which provided some assurance that our concerns had started to be addressed.

The trust undertook stakeholder engagement with service users to gain their feedback on what was important to service users.

The trust used a variety of approaches which included surveys, interviews and focus groups to help understand what was most important to patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services however, due to operational pressures this had not been a priority within the service. Previously the service had a number of staff trained in quality improvement methods and the skills to use them however, many had left the service.

Surgery

The Patient First Improvement System had been implemented across the trust. Patient First is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for patients and staff. The focus of the system is on empowering front-line staff to make improvements themselves. Staff were given training in the tools to work out where opportunities for improvement are in their daily work and to develop the skills to make sustainable change happen.

Staff in theatres and recovery told us that they were disengaged from the Patient First Improvement System as many of those trained in using the system had left. The leadership team told us that they wanted to reinstate the Patient First Improvement System and use it as a method to drive change and tackle many of the concerns and challenges within the service.

In September 2021, the Patient First Improvement System team worked with a consultant anaesthetist and lecturer to develop training and coaching for junior doctors to help them to work on their own quality improvement projects. A further session will take place in November with an estimated 35 doctors planning to attend.

Areas for improvement

Action the trust MUST take to improve:

The trust must operate effective governance systems to ensure compliance with all relevant sections as set out in Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1)

The trust must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2)(c)

The trust must ensure it improves its management of risk and issues and ensure they can plan effectively to tackle patient safety issues. Regulation 17(1)

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

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

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

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

The trust must ensure all staff follow the trust's infection control policy and national guidelines in relation to infection prevention and control. Regulation 12 (2)(h)

The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b)

The trust must ensure that managers have the required skills, knowledge experience to lead the service. Regulation 18 (b)

Surgery

SHOULDS

The trust should ensure that:

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

Surgery core service

Action the service MUST take to improve:

The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2)(c)

The service must ensure that staff working in theatres have the qualifications, competence, skills and experience to keep patients safe. Regulation 12 (2)(c)

The service must ensure all staff follow the trust's infection control policy. Regulation 12 (2)(h)

The service must ensure that patients receive surgery when they need it and do not experience delays, placing patients at the risk of deterioration and harm. Regulation 12 (2)(a) and Regulation 12 (2)(b)

The service must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b) (e)

The service must ensure all risks are escalated as appropriate and documented on the relevant risk register. Regulation 17 (2)(b)

The service must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b)

The service must undertake scheduled audits and take action to address poor performance in order to monitor the safety and quality of the service. Regulation 17 (2)(b)

The service must ensure it improves flow in the hospital and theatres to reduce the time patients spend in the recovery unit waiting for a bed in the hospital. Regulation 12(1)

The service must ensure it has suitable facilities to care for patients requiring high dependency or intensive care. Regulation 12 (2)(b)

The service must ensure nurse staffing levels meets the needs of patients and national guidelines. Regulation 18 (1)

The service must not care for patients with high dependency needs in recovery without an appropriate standard operating procedure and risk assessments. Regulation 17(2)(b)

The service must ensure that all rooms display the maximum safe occupancy. Regulation 12 (2)(h)

Surgery

The service must ensure their governance processes link with all staff to provide a safe service. Regulation 17

The service must ensure patients experiencing prolonged periods of time in recover have their privacy and dignity maintained. Regulation 17(2) (a)

Action the service SHOULD take to improve:

Surgery core service

The service should ensure action is taken regarding identified themes to resolve concerns. Regulation 17 (2)(e)

The service should ensure it provides continuous professional development to all staff. Regulation 18 (2)(b)

The service should continue to complete and review the action plan developed for theatres and recovery.

The service should consider the views of staff with regards to culture and take appropriate action.

The service should consider how it improves the storage space and facilities within main theatres.

The service should consider how it improves communication and decision making between the senior executive team and clinical leaders within the surgery division.

The service should consider reviewing the strategy and vision of the service to ensure it still fits the service needs.

The service should consider how to ringfence time for teaching and training for theatre and recovery staff.

The service should consider how to recommence theatre and recovery unit meetings and ensure these follow a set format, include who has attended and discuss key issues.

Maternity

Inadequate ↓↓

We carried out this unannounced focused safety inspection of maternity services, provided by the University Hospitals Sussex NHS Trust (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 NHS trust 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 the Royal Sussex County 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 and at the Royal Sussex County Hospital there were 80 responses. The anonymous results related to the Royal Sussex County Hospital have been used as evidence to support our report.

This inspection has not changed the ratings of the location overall. However, our rating of maternity services went down. Overall, we rated safe and well-led as 'inadequate' we did not have enough evidence to re-rate the effective domain.

Our rating of this location 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 did have training in key skills. The service did not always control infection risk well. Staff did not always keep good care records. The service did not manage safety incidents well and did not always learn lessons from them. Staff did not use nationally recognised tools to triage women for treatment.

Leaders did not run services well or support staff to develop their skills. Staff did not understand the service's vision and values or how to apply them in their work. Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities. Staff collected safety information, but this was not always accurate.

However:

Staff understood how to protect women from abuse.

They managed medicines well.

Staff assessed risks to women and acted on them

They were focused on the needs of women receiving care.

The service engaged well with women and the community to plan and manage services.

Maternity

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

Staff did not always receive or keep up to date with their mandatory training. Some staff told us that although annual mandatory training was provided by the trust they could not attend because they were needed to work in clinical areas of the department. The service had a target of 90 % staff attendance at mandatory training. Records showed that average attendance for nursing and midwifery was 81.27% and for medical staff it was 70.28%. This was worse than the trust target of 90%.

The mandatory training provided was comprehensive and met the needs of women and staff. The mandatory training met the standards required to meet Health and Patient Safety standards for clinical and non-clinical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they would receive an email to notify them when they needed to attend mandatory training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff did not all have training on how to recognise and report abuse however they knew how to apply it.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The service had a training attendance target of 90%. Records showed 73.3% of nursing and midwifery staff had attended safeguarding training specific for their role. This was worse than the trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse. The service had a training attendance target of 90%. Records showed 45.5% of medical staff had attended safeguarding training specific for their role. 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 and worked with other agencies to protect them. During the inspection we observed staff discussing safeguarding risks and clearly identifying adults and children who may be at risk of harm. During handover the staff noted a patient's family members had been verbally aggressive to staff and ensured they had time alone with the patient to explore the situation in more detail.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During the inspection we reviewed the Safeguarding Children and Child Protection – Maternity Protocol. This document was seven months overdue for review and referred to out of date intercollegiate guidance. However, staff of all grades could describe how to make a safeguarding referral and who to inform. The department had two safeguarding midwives who visited the clinical area daily during the week to support staff.

Staff followed the baby abduction policy but had not undertaken recent baby abduction drills. The trust had a baby abduction policy which was seven months overdue for review. During the inspection staff told us they had not recently undertaken baby abduction drills. Records showed that 46% of midwives had attended skills drills training in the 12 months before inspection. This was much worse than the training target of 90%.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff did not always use infection control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Although the majority of staff were bare below the elbows, we observed some staff wearing long sleeved cardigans over their uniforms. We observed most staff washed or decontaminated their hands before giving care. All clinical areas had supplies of PPE including gloves, aprons and antibacterial hand gel.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. We observed staff using equipment after patient contact and not cleaning it afterwards. For example, when taking patients observations with a blood pressure monitor and thermometer. There was no labelling of equipment to show when it was last cleaned. We observed a trolley in the nursery nurses' room on the post-natal ward was dusty.

Ward areas were 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.

The service generally performed well for cleanliness. In the last Patient-Led Assessments of the Care Environment (PLACE) 2019 – England the Royal Sussex County Hospital scored 98.55% for cleanliness of the environment. This assessment has not been repeated since 2019 due to the Covid pandemic.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed records for three months before the inspection and found them to be fully completed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use the equipment. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. In all clinical area's records showed that specialist equipment was not checked on a daily basis. Every month for the previous three months records showed checks had not been completed on two to seven days over the month. On the post-natal ward, the inspection team found a paediatric defibrillation pad that had expired a year before the inspection on the resuscitation trolley. This meant staff could not be assured the checks completed were identifying expired pieces of equipment. The midwife in charge of the ward was informed at the time and removed the item immediately.

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

Maternity

Women could reach call bells, but staff did not always respond quickly when called. We observed call bells ringing for more than ten minutes before a staff member was available to answer the call bell. Women often came to the ward office to get the attention of staff if they needed assistance. Nursery nurses told us they would answer bells even when it was not part of their role and become caught up trying to find a midwife for the women. This was time consuming and taking them away from their role.

The design of the environment in most clinical areas followed national guidance. Mothers and babies were kept secure on the maternity unit. There was secure access to the central delivery suite, ante-natal and post-natal wards. 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.

Staff told us the second maternity theatre could only be accessed via a lift that had a history of breaking down. This lift was not for public use and was generally used to remove clinical waste from the ward areas. The lift required a key to access it. The staff planned their workday to avoid using the second theatre as they considered the delay in accessing the theatre a risk in an emergency situation. Records showed this risk was recorded on the maternity risk register.

Staff on the labour ward were concerned that the emergency bell could not be heard from the office. We were given an example of when a midwife had pulled the emergency buzzer and no doctor had attended as they could not hear the emergency buzzer in the office.

The rooms on the labour ward were small and if specialist equipment was needed during the labour the furnishings in the room needed to be rearranged to accommodate the equipment.

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 bereavement area called The Willow Suite. It was situated away from the labour ward and had a delivery room, bedroom area and facilities to make tea and coffee. It was a very relaxed and homely area. This area had been developed with support from the Stillbirth and Neonatal Charity (SANDS).

Staff generally disposed of clinical waste safely. We reviewed sharps bins in all clinical areas and found one that had not been assembled correctly as the labelling on the outside had not been completed. Clinical waste was separated and placed in the correct bins. Waste was stored in locked bins while waiting to be removed from the hospital site.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman or take action to remove or minimise risks. Staff did not always identify and quickly acted upon women at risk of deterioration.

Staff did not use a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff in the maternity triage department told us they did not use a tool such as the Birmingham symptom-specific obstetric triage system (BSOTS) but relied on their clinical experience to assess women attending the department. As midwives with little clinical experience were staffing the triage department this was a significant risk for women attending. The Royal Society of Obstetricians and Gynaecology guidelines recommend that an initial standardised assessment of each woman which identifies her presenting condition, key clinical symptoms and physiological indicators should be undertaken on admission.

Maternity

Staff told us women in the maternity assessment unit were reviewed by a midwife within one hour of arrival but waited up to six hours to be reviewed by a doctor. The National Institute for Health and Care Excellence guidelines for safe midwifery staffing (2015) defined a delay of 30 minutes or more between presentation and triage as a 'red flag event'. This long wait for clinical assessment was a significant risk for women attending the department.

Staff completed risk assessments for each woman on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff told us they used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed five MEOWS charts during the inspection and found them to be correctly completed and concerns had been escalated to senior staff.

Staff knew about and dealt with any specific risk issues. Each woman had a patient care record which contained a variety of risk assessments. We reviewed ten sets of patient care records and found all risk assessments to be completed fully.

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

Shift changes and handovers included all necessary key information to keep women and babies safe. During the inspection we attended a number of staff handovers in the clinical area and found all the key information needed to keep women and babies safe was shared. Staff told us that although they planned safety huddles during the shift to update the team with any changes this had not been happening due to lack of time. Staff told us that they used to have two safety huddles a shift to ensure all staff were up to date with key information but due to staff shortages a safety huddle occurred once a week if staffing allowed. Each member of staff had an up to date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each patient.

Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels, and gave bank and agency staff a full induction.

The service did not have enough midwifery staff to keep women and babies safe. All staff we spoke to before, during and after the inspection told us that low numbers of staff made them feel unsafe. Staff were allocated to areas they were unfamiliar with at short notice to cover gaps in the rota. For example, a midwife told us they had been sent to work on the labour ward when they were employed to work on the antenatal ward. They felt out of their depth on the labour ward but felt obliged to work there due to low numbers of staff.

All staff we spoke to put low staffing numbers as their biggest concern. Comments we recorded from staff included "staff are exhausted and on their knees", "I feel it is only a matter of time before something bad happens", "Staff are reduced to tears every day because it is so short staffed", "I have a constant sense of dread that something awful will happen", "I cannot even relax on my day off worrying if I might have made a mistake", and "I am looking for another job I just do not want to work here anymore".

Maternity

Staff told us that low numbers of trained staff delayed women being discharged home. In particular new mothers were waiting up to six hours to have a midwife assessment before being discharged. Staff of all grades told us in was unusual to get a break while on duty and often went home feeling dehydrated and exhausted.

All staff told us that they were unable to provide the standard of care they wanted to. For example, the midwives told us they had too many women to care for at one time in the antenatal, postal natal and triage area they were frightened of missing a deteriorating woman or baby.

Midwives were often doing baby transitional care, normally completed by nursery nurses, as well as looking after the women who had recently given birth. This was because there were not enough nursery nurses on duty.

A home birthing service was available to patients who were assessed as suitable. There was a home birth midwife on duty who worked as a supernumerary member of staff. The safety of providing the home birthing service was assessed by the labour ward coordinator at the change of each shift. It would be suspended if there were not enough midwives to ensure the service could be provided safely.

The labour ward coordinator should work as a supernumerary member of staff to lead the shift, coordinate the care and provide senior clinical support to the midwives caring for women in labour. Staff told us this rarely happened due to the shortage of midwives. This meant the coordinator had their own patient to care for as well as being responsible for the rest of the labour ward.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. However, when we reviewed the staffing rotas we saw there were gaps in the planned number of midwives, nursery nurses and maternity healthcare assistants in the majority of shifts. Staffing on the labour ward the night before the inspection should have been 13 members of staff but they only had nine until 2 am and then reduced even further to seven staff for the rest of the shift. This staffing level was not unusual.

The ward manager could adjust staffing levels daily according to the needs of women. Managers moved staff according to the number of women in clinical areas however staff told us this was at short notice and they were often expected to work in areas that were unfamiliar to them.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. Twelve midwives had left the service in the six months prior to the inspection. Staff told us sickness rates were increasing as staff became more stressed. The head of midwifery told us exit interviews were conducted by the line manager and was unable to provide any themes or trends from recent exit interviews. Records showed there was a 51% vacancy rate for Band 5 midwives. The inspection team also noted the trust had over the establishment of band 6 and band 7 midwives but this had no impact on the staffing levels because of the high number of vacancy levels in the band 5 group.

Managers made sure all bank staff had a full induction and understood the service. Bank staff were usually sourced from the normal workforce and were familiar with the service. Managers had not given permission to source staff from agencies.

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

Records

Maternity

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

Women's notes were comprehensive, but all staff could not access them easily. The majority of women's notes were stored on an electronic patient record and the rest were paper notes. Each healthcare professional who had contact with the women recorded their care in the electronic patient record.

We reviewed ten electronic patient records during the inspection and found all the electronic patient records to be fully completed. Staff told us there were areas in the hospital with poor access to wireless internet and women's records could not be accessed in these areas. This meant staff could not always access patient records easily.

We reviewed five paper notes and found them to be hard to follow as they were not always fully completed. In two sets of notes we found documents belonging to other patients on the ward. We informed the staff, and this was corrected on the day of inspection.

When women transferred to a new team, there were no delays in staff accessing their records. Both the community and hospital team caring for the women had access to the electronic patient record which contained the most recent information about the women's care.

Records were not stored securely. In all clinical areas we visited the women had a secondary set of paper notes which contained details of their inpatient care episode. These were stored in notes trollies with electronic digital combination locks. All of the note's trollies were unlocked on the day of inspection. This meant the notes could be accessed by people without the authority to do so.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The women had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found them to be correctly completed.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. A pharmacist visited the ward daily and reviewed the medicines prescribed to each woman. Evidence of these checks was visible in the prescription charts we checked on the day of inspection.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. The clinical rooms where the medicines were stored on the antenatal, post-natal ward and labour ward was locked and could only be accessed using a swipe card issued to authorised staff. Controlled drugs were stored in a lockable cupboard attached to the wall. Records showed controlled drug stocks were checked daily except on one occasion on 25 August 2021. Records showed that controlled drugs had been received from pharmacy and stored in the controlled drug cupboard without a witness signing to confirm they had been received.

The refrigerator that stored medicines was checked daily to ensure the temperature was within the correct levels. Records showed that these checks were missed on eight occasions in August and September 2021. On the day of the inspection the fridge contained influenza vaccines that had expired in July 2021. We notified the midwife in charge and they were removed.

Staff followed current national practice to check women had the correct medicines. We observed staff following current national practice when administering medicines.

Incidents

The service did not manage safety incidents well. Staff recognised but did not have time to report incidents and near misses. Managers did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff we spoke to were clear on what incidents were reportable and how to use the electronic reporting system. We reviewed ten incidents reported in the three months before inspection and found them to be reported correctly.

Incidents were reviewed at a monthly incident review meeting. Once the incident had been reviewed the outcome was shared with the staff member who reported the incident but not with the wider team.

Staff did not raise concerns or report incidents and near misses in line with trust policy. Staff told us they often did not have time during the shift to report incidents and only reported what they considered to be a serious incident after their shift had finished. This meant all reportable incidents were not being regularly reported. Staff told us they had been instructed to stop reporting low staffing as an incident as it was a known risk.

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

Managers did not share learning with their staff about never events that happened elsewhere. Staff told us that due to a shortage of staff they had not been meeting to discuss learning from never events occurring elsewhere within the trust. This meant staff did not have an opportunity to learn and change their practice or improve the service through learning. Staff were aware of a system called ‘message of the week’. This was a paper bulletin with a safety message and was displayed in the office. However, staff told us they were too busy to read this message and no one asked could recall a recent safety message that had been shared.

Staff reported serious incidents clearly and in line with trust policy. If a serious incident had occurred during the shift staff would remain on after the shift to report the incident in their own time.

Staff did not all understand the duty of candour. Although each clinical area had leaflets on display explaining duty of candour not all staff we spoke to could tell us what it was. Duty of candour is a legal obligation to be open and transparent with patients when something had gone wrong.

Staff did not receive feedback from investigation of incidents, both internal and external to the service. Staff told us they only received feedback on incidents they had reported and were unaware of any wider learning either internal or external to the service.

Staff did not meet to discuss the feedback and look at improvements to patient care. Staff were aware of a system called ‘message of the week’. This was a paper bulletin with a safety message and was displayed in the office. However, staff told us they were too busy to read this message and non could recall a recent safety message that had been shared.

Maternity

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We reviewed three serious incident investigations and found they involved women and their families. All three had evidence of duty of candour and draft reports being shared with the families for comment.

Managers debriefed and supported staff after any serious incident. We reviewed three serious incident investigations and found they contained a list of staff who would be offered debriefing and support following the serious incident.

Safety Data

The service used monitoring results to improve safety. Staff collected safety information but did not shared 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. Clinical indicators that were outliers were denoted in red. Improvement or decline in performance could be tracked over time.

Is the service effective?

Inspected but not rated

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

The service participated in relevant national clinical audits. Records showed the service participated in relevant national audits which included recent recommended audits by the maternity Ockenden Report.

Outcomes for women were positive, consistent and met expectations, such as national standards. We reviewed the Regional External Panel Review Assurance and Action Plan for maternity which showed assurance that they were not an outlier for the number of neonatal deaths and 3rd and 4th degree tears.

Managers and staff used the results to improve women's outcomes. We reviewed the Regional External Panel Review Assurance and Action Plan for maternity which showed clear actions to improve women's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. Records showed that audit results were discussed in monthly audit meetings. These meetings were minuted and the minutes distributed to staff electronically.

Competent staff

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

Maternity

Staff were not experienced, qualified or have the right skills and knowledge to meet the needs of women. Staff told us they had been unable to practice live drills, pool evacuation and Cardiotocography (CTG) training recently as they were so short of staff. The service had a training attendance target of 90%. Records showed that 51% of midwives had attended CTG training in the 12 months before inspection. Records showed that 46% of midwives had attended skills drills training in the 12 months before inspection. This was much worse that the training target of 90%.

Managers did not always give all new staff a full induction tailored to their role before they started work. Staff told us it was not always possible to complete a full supernumerary induction due to the shortage of staff. The inspection team were given examples of staff of all grades who worked as part of the team before their induction programme had been completed.

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. Staff told us they received a tremendous amount of support from the PMA team. Staff told us they were concerned that two PMAs had left and had not been replaced.

The clinical educators supported the learning and development needs of staff. Staff told us the clinical skills facilitators were very supportive and worked clinically alongside the midwives to maintain their clinical skills.

Managers did not ensure staff attended team meetings or had access to full notes when they could not attend. When staff meetings took place, minutes were recorded and shared with staff who could not attend due to staffing shortages

Staff did not have the opportunity to discuss training needs with their line manager and were not supported to develop their skills and knowledge. Staff told us there were few opportunities to complete additional training.

Multidisciplinary Working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The inspection team observed four multidisciplinary meetings during the inspection. Three meetings were end of shift handover meetings and one was a ward round. They were attended by midwives, midwifery care assistants, nursery nurses and doctors.

Staff described good working relationships with all members of the clinical team including midwives, nursery nurses, midwifery care assistants, obstetricians and anaesthetists. During the inspection we observed positive and supportive interactions within the multidisciplinary team.

Obstetricians were on the hospital site until 8.30 pm every day. After that time there was an on-call rota and clinical advice could be sought over the telephone or the obstetrician would come to the hospital in person.

Is the service well-led?

Inadequate 

Maternity

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

Leadership

Leaders did not have the necessary experience or capacity to lead effectively and abilities to run the service. 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 post was vacant at the time of inspection. The head of midwifery was cross-site and covered both the Princess Royal Hospital site and the Royal Sussex County Hospital site and in the absence of the director of midwifery post, reported directly to the Chief Nurse who represented the service at trust board level and was the maternity safety champion for the trust. There was an inpatient matron and a community matron, and a governance and safety lead who reported into the head of midwifery.

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 a standard agenda but did not record attendance.

Staff told us they did not always feel supported during a shift. For example, they found some managers were not approachable and were reluctant to raise concerns with them. They would either not raise a concern or wait until an alternative manager was on duty. Staff told us their effort was not recognised or praised by managers.

Staff starting leadership roles told us they felt unsupported and did not have a clear development plan. They felt obliged to work clinically due to the shortage of midwives and were not able to focus on their leadership objectives.

Staff told us they felt pressurised by the senior leaders to work extra shifts even though they were exhausted, and this showed a lack of understanding of the current situation on the ward areas. Managers verbally acknowledged that low staffing was a problem but did not have a plan to improve the situation.

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 and support 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.

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."

Staff were not able to describe the vision and strategy. Their main concern was supporting their colleagues and ensuring the women and babies in their care were safe. They felt disconnected from the trust vision or strategy for the future.

Culture

Staff did not feel respected, supported and valued by leaders. The staff were focused on the needs of patients receiving care.

All staff we met during our inspection were welcoming, friendly and helpful. They felt pride in the peer support they provided each other and having worked together to provide the best service they could to patients in their care.

The Care Quality Commission surveyed maternity staff between 1 September and 15 September 2021, to explore how staff felt about the culture of their department. Combining the survey responses and staff feedback during and after the inspection told us staff felt disrespected, unsupported and undervalued by the leadership team. Quotes from the survey included “There is inadequate leadership, staffing, and an inability to address a culture which is failing families” and “Staff morale is exceptionally low at the moment”.

Staff told us of incidents of bullying and intimidation amongst their colleagues.

Staff had raised concerns about the safety and culture of the service on multiple occasions and told us nothing had been done to improve the situation. Staff who had worked for the service for many years were taking early retirement or seeking employment elsewhere. Staff told us this unit ran on the loyalty and hard work of the staff and this was “coming to an end”.

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

Governance

Leaders did not operate an effective governance process, throughout the service and with partner organisations. Some staff were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

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 midwifery and reported to the chief nurse for the trust as the post of director of midwifery was vacant at the time of inspection.

The triumvirate leadership team used the governance structure to inform the maternity board about the current risks within the service. The governance structure included the patient safety group, patient experience group and finance group. These groups met monthly and discussed issues using a standard agenda template. The governance team membership included the education team, fetal wellbeing midwife, audit midwife, practice education midwife, risk midwife, bereavement team and complaints manager.

The governance processes in place did not alert the senior leaders to the concerns of the workforce in the clinical areas. Staff told us they had given up reporting staffing issues as nothing was changing.

Clinical areas had posters with the monthly dates for audit meetings, governance meetings and mortality and morbidity reviews. Most staff told us they did not have time to attend meetings or discuss and learn from the performance of the service. An out of date audit strategy document covering 2017 to 2020 was on display for information.

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 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. However, staff told us not all risks were recorded as were often repeated or ongoing without resolution.

The triumvirate leaders told us the top three risks for the service was staffing, only having one maternity theatre and the temperature on the wards. The risk register showed the top three recorded risks for the service were unsafe staffing levels, community temporary premises and delays in care due to antenatal capacity. Staff were not given the time to be able to undertake required training or practice for emergency situations impacting on effective performance.

The themes from serious incidents and lessons learned included managing induction of birth, ruptured membranes and escalation of concerns. These cases were reviewed by the Healthcare Safety Investigation Branch. The maternity service had referred 19 cases to the Healthcare Safety Investigation Branch since 2018.

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 did not always collect reliable data for analysis. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and rarely for improvement.

Maternity

The service had electronic systems for collecting and analysing data. Electronic service user record systems in Maternity did not always support staff to maintain contemporaneous care records because of connectivity or system glitches. For example, the poor internet connection on level 5 in the Royal Sussex County Hospital meant staff could not access the electronic service user record. 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. The used their judgement to decide what incidents were worth reporting. This resulted in incomplete data and it was not possible to assess and improve performance. In addition, 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.

Information was not always managed well enough for reliable analysis, for example the maternity triage service was not using a standardised system for data recording to reduce the risk of unnecessary harm and was a subjective risk assessment.

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.

Engagement

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

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.

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 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.

Maternity

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

MUSTS

Royal Sussex County Hospital Maternity

Action the trust MUST take to comply with its legal obligations

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 a. receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2)).

The trust must ensure safe staffing levels at all times. (Regulation 18 (1))

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

The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and in particular clinicians 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)).

SHOULDS

Royal Sussex County Hospital Maternity

The trust should ensure that

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

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

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

Our inspection team

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