Kingston Hospital NHS Foundation Trust

Kingston Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Kingston Hospital

Good 

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

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

We carried out a short notice announced focused inspection of the Maternity service, looking only at the safe and well led key questions.

We did not rate this hospital at this inspection. The previous rating of good remains.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good

Maternity services at Kingston Hospital, South West London, include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care.

The maternity unit included a consultant-led delivery suite, maternity triage, and wards for antenatal, postnatal and transitional care. The alongside midwifery-led birth centre provided intrapartum care for women and birthing people who met the criteria and are assessed to have lower risk pregnancies. The birth centre has 4 birthing rooms, all of which have birth pools and ensuite facilities.

In the calendar year 2021 there were 4536 deliveries at Kingston Hospital of which 18% of births were at the alongside midwifery led unit (birth centre). The home birth rate was 6%.

We rated this location good overall because:

- Leaders ran services well and staff felt respected, supported and valued. Managers monitored the effectiveness of the service. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.
- The service managed safety incidents well and learned lessons from them.

However:

- The service did not always have enough staff to keep women and birthing people safe.
- Appropriate medical review for women attending maternity triage was not always timely.
- Not all staff were up to date with training in key skills.
- The security of the unit did not keep women and babies safe at the time of the inspection.

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff, but staff were not up to date with training updates. Staff did not always complete regular skills and drills training.

Staff received but were not up to date with mandatory training. The summary maternity workforce training database for October 2022 showed all 14 maternity mandatory training modules were below 75% compliance against a trust target of 90%. Total staff compliance ranged between 27% for the midwifery support worker virtual focus day and 70% compliance for the infant feeding update. The trust had an action plan to improve compliance with mandatory training to meet the 90% trust target by the end of March 2022.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed 'professional obstetric multi-professional training' (PROMPT) training once a year. Data showed as of September 2022 82% of staff had completed yearly PROMPT training, 80% of had completed neonatal or basic life support training as of October 2022 and as of August 2022, 91% of staff had completed fetal monitoring training.

Midwifery staff also completed a 'focus day' of training every year that covered topics including bladder care, medicines management and blood transfusion.

Staff did not always complete regular skills and drills training. For example, the last birth pool evacuation training on the birth centre was in November 2019 and the trust did not provide evidence of a recent skills training to test the security of newborn infant's policy. Following the inspection visit on 11 October 2022 when we raised concerns about the security of the unit, the trust completed a skills drill to test the abducted baby process on 17 October 2022.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, midwives did not always have access to regular safeguarding supervision.

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with had completed online safeguarding training in the past year. As of July 2022, 73% of staff had completed yearly face to face child protection training with the maternity safeguarding team. The training was in line with the London child protection document and the intercollegiate document and included live case scenarios. Data provided by the trust was not explicit on the number of staff who had completed safeguarding to level 3 where required.

Midwives did not always receive safeguarding supervision on a quarterly basis. This was due to lack of trained staff to deliver safeguarding supervision as only 1 midwife was a trained supervisor and they worked 0.5WTE. Leaders recorded and mitigated this risk and the safeguarding lead midwife told us there was a safeguarding supervision recovery plan that was on target to achieve improved compliance. The named nurse for safeguarding children was delivering supervision to support the team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the 'bridge team' which was made up of safeguarding specialist midwives and perinatal mental health midwives who oversaw the care of vulnerable women having babies at Kingston Hospital. The service ran a weekly antenatal 'bridge team' clinic led by a consultant with an interest in mental health, a specialist perinatal mental health midwife and a perinatal psychiatrist.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. Between May and September 2022 compliance was consistently above 95% except for 1 month when compliance on the birth centre was 90% and 1 month when compliance on Thameside antenatal ward was 90%.

The deputy chief nurse and infection control specialist nurse completed an infection control walkabout audit in September 2022 and was taken to address areas where dust was found such as at the bases of equipment.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. For example, we saw staff clean couches between use in the antenatal clinic. Staff used 'I am clean' stickers to show equipment was clean and ready for use but these were not always used consistently as we did not see them used on all equipment.

Leaders monitored rates of sepsis infections in labour and postnatally. Between April and September 2022 there were 9 incidents of sepsis in labour and 4 incidents of sepsis in the postnatal period.

Environment and equipment

The maternity unit was not fully secure. The use of facilities, premises and equipment were not always managed in a way that kept people safe.

The design of the environment did not follow national guidance in all areas. The maternity unit was not fully secure. While there was a monitored buzzer entry system to the maternity unit. People then had access to the whole of the first-floor maternity unit which included unrestricted access to central delivery suite, the birth centre and maternity triage. It was possible to exit the first-floor maternity unit through an unmonitored exit. Following the inspection, the trust completed a review of the security of the unit.

The layout and design of the day assessment unit area did not always enable staff and women to have confidential conversations. It contained 2 couches and 1 chair. It was not private, and all conversations could be overheard even when staff spoke quietly. The trust told us staff had access to a quiet room if needed but we did not see this in use at the time of inspection.

Staff did not always complete daily safety checks of specialist equipment. For example, adult resuscitation equipment outside maternity theatres was not checked on several dates including the day of inspection. On day assessment unit the defibrillator had not been checked.

The July to September 2022 resuscitaire checklist audits showed 62% of resuscitaires were checked at every shift. This did not meet the trust target of 95% compliance. Actions to improve compliance included team leaders carrying out monthly checks and discussing the results of the audit at the local risk meeting. The audit noted high acuity and low staffing levels as a reason for low compliance.

Most equipment we reviewed was in date for servicing. For example, all equipment we reviewed in the day assessment unit had been serviced within the last year and displayed labels to confirm this.

The service had suitable facilities to meet the needs of women's families. For example, on the alongside midwifery-led unit women had access to birthing pools, birth balls and stools to support movement in labour. The birth centre rooms had recently been refurbished to provide a calm and homely environment.

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

Staff disposed of clinical waste safely. Sharps bins were labelled correctly. However, we noted a clinical waste bin in maternity triage that did not have a lid.

Assessing and responding to patient risk

In maternity triage staff did not always ensure women were reviewed by an appropriate doctor in a timely way when they may have been at risk of deterioration. However, across the service staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

At the time of inspection, staff used an evidence-based, standardised risk assessment tool for maternity triage. This tool rates the urgency of obstetric review needed from red, the most urgent (immediate transfer to labour ward and obstetric review) to green the least urgent (junior obstetric review needed in 4 hours).

Women in maternity triage were not always seen in a timely way by medical staff and the service did not monitor waiting times. We reviewed the maternity triage waiting times for doctor review audit completed for data between July to September 2022. The audit of 8 sets of notes month 58% women were reviewed by the triage midwife within 15 minutes of arrival. Compliance with women being reviewed by an obstetric doctor of the appropriate grade was 45% for women who needed senior obstetric review within 15 minutes and 30% for women needing junior obstetric review within 1 hour. The audit showed one woman rated orange needing senior obstetric review within 15 minutes waited up to 5 hours for review with the average wait time being 55 minutes.

Staffing in maternity triage was not sufficient to fully implement an evidence-based, standardised risk-assessment tool for triage effectively as maternity triage was staff by only 1 midwife and there was no dedicated medical cover. Staff told us they would escalate clinical concerns when needed and that there were times when consultants would review patients in the day assessment unit. However, they could not confirm that they escalated within 15 minutes for high risk women.

After inspection the trust submitted a triage action plan with immediate actions to be implemented immediately including: a maternity support worker being allocated to triage at all times, triage front desk staff logging arrival times and flagging delays to the maternity bleep holder, obstetric consultant, registrar and SHO cover has been reviewed and a rota ensuring attendance at triage was prioritised. Longer term actions included recruiting 11 whole time equivalent (WTE) midwives trained in maternity triage, improving the environment for maternity triage and continuous audit of triage performance.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS). The use of MEOWS was taught in the multidisciplinary emergency skills training day. Staff did not always record and escalate MEOWS observations effectively. In 4 out of the 7 records we reviewed MEOWS observation chart scores were not totalled up to confirm whether action was needed to escalate. MEOWS was not used in day assessment unit and maternity triage. Staff told us MEOWs would only be completed if women and birthing people were admitted to the maternity unit. Every quarter, leaders completed an audit of 10 MEOWS records to check they were fully completed and escalated appropriately. Data showed the last 2 audits for June and September 2022 scored 100%.

Maternity

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle. Staff told us that there was a period of 4 months when the trust was unable to source the single use cardboard tubes required to fit into the existing devices, due to a national shortage. The trust purchased new carbon monoxide monitors to mitigate the risks of this shortage.

Staff risk assessed women continually antenatal and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

If women and birthing people had concerns about their pregnancy and were 18 weeks pregnant or more, they could call a maternity helpline that was open 09:30 – 19:30. Outside of these hours the calls were picked up by the 24 hour maternity triage service. If staff identified concerns following an initial call woman were asked to attend day assessment unit or maternity triage.

Staff knew about and dealt with any specific risk issues. For example, staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. The service had embedded a physiological approach to fetal monitoring. Managers audited compliance with women having continuous CTG monitoring during labour. Data for the July to September 2022 audit showed there was appropriate interpretation and management plans following CTG in 100% of cases and 'fresh eyes' were completed at each hourly assessment in 93.5% of cases. However, hourly assessments were only completed in 13% of cases.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.'

Staff shared key information to keep women safe when handing over their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. Managers monitored the effective use of handover of care and the SBAR tool. Data from the July to September 2022 audit showed handover was carried out using the SBAR format in 100% of the time the cases reviewed.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed between April and August 2022 average compliance was 100%.

Women who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a consultant midwife to discuss risks and options available to create a suitable birth plan together.

The service did not always achieve targets for timely completion of newborn infant physical examination screening (NIPE). Leaders monitored performance against the NIPE standards and had an improvement plan to improve timeliness of completion of examinations and onward referrals.

Midwifery Staffing

Staffing levels impacted negatively on the safety of the maternity unit and were not sustainable due to high turnover and sickness rates. The number of midwives and healthcare assistants did not always match the planned numbers and staffing levels impacted negatively on the safety of the unit.

Maternity

Midwifery staffing levels impacted negatively on the safety of the maternity unit. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Data showed in September 2022 there were 69 red flag incidents, with the most common incident being delayed induction of artificial rupture of membranes (ARM) to central delivery suite in less than 6 hours with 45 of this type of incident.

On the day of inspection midwifery staffing should have been 17 midwives plus 1 supernumerary coordinator but it was 13 midwives plus 1 supernumerary coordinator. As part of the staffing escalation policy specialist midwives and matrons worked clinically when midwifery shifts were not filled. Specialist midwives and matrons frequently covered clinical shifts during the day and matrons were on an on-call rota overnight.

Maternity triage was open 24 hours a day, 7 days a week and was staffed by 1 midwife for every 12-hour shift. We observed the midwife admitting a patient whilst the phone was ringing, then having to answer the phone whilst trying to complete the other patients record. Multi-tasking can lead to errors and this staffing level was not in line with national guidance which advises, 2 experienced midwives must work on each shift, with support from 1 registrar doctor at all times.

Midwifery staffing levels impacted on the sustainability of the birth centre service. Due to staffing challenges there were 22 birth centre closures in August 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 220.69 WTE midwives' band 3 to 8 were needed against the current funded staffing of 211.9 WTE, a shortfall of 8.99 WTE staff.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service. The bleep holder completed the staffing acuity tool every 4 hours. The service used a traffic light red, amber, green system to determine the capacity of the unit. Green status means the unit is functioning at normal capacity, amber status means there are insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and red status would lead to a decision to close the unit. The unit leader updated the traffic light status 4 times during a 24-hour period. Staff we spoke with told us the acuity tool showed recently staffing was always amber or red. This was confirmed by maternity safer staffing data for 2022 which showed the maternity day staffing rate was 73% filled registered midwife day shifts in July, 82% in August and 87% in September.

The service had high turnover rates for midwives and midwifery support workers. Data presented in the September 2022 staffing report to the trust board showed turnover for midwives was 18% and for maternity support workers it was 32% against a trust target of 14%.

The service had high sickness rates. Data presented in the September 2022 staffing report to the trust board showed sickness was 6% for midwives and 8% for maternity support workers against a trust target of 3.5%.

The service had low vacancy rates on current establishment plans. Data presented in the September 2022 staffing report to the trust board showed the vacancy rate for midwives was 7% and 3% for maternity support workers against a trust target of 7%.

Maternity

The service did not use agency midwifery staff. Staff told us leaders offered enhanced rates of pay to midwives who worked bank shifts to cover gaps in rotas.

Managers supported maternity staff to develop through yearly, constructive appraisals of their work. At the time of inspection data showed 72% of midwives had received a yearly appraisal. Midwives were supported by a practice development team which included 2 practice development lead midwives, a clinical preceptorship support midwife and a practice development midwife. At the time of inspection, the team was out to advert for a further band 7 practice development midwives.

Managers made sure staff received any specialist training for their role. For example, data showed 10 midwives had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

The service had 10 maternity community teams staffed by 45 midwives (37.19 WTE). The latest activity, staffing and acuity review reported in January 2022 showed that a total of 78.99 WTE midwives were needed to rollout continuity of carer throughout the service, a 21% uplift. While the national continuity of carer programme was stepped down at the time of inspection, to reduce disparities in health outcomes, the trust was prioritising Black, Asian or Mixed ethnicity women and women from areas of high deprivation for the continuity of carer service. Data presented to the trust board on maternity continuity of carer showed between March 2021 - Feb 2022, 42% of all women booked at Kingston Hospital received continuity of carer at 29 weeks pregnant, which included 45% of women from a Black, Asian or Mixed ethnicity and, 70% of women from areas of high deprivation.

The service was involved in a maternity support worker project with Health Education England to develop a national competency framework for maternity support workers.

Medical staffing

The service did not always have enough medical staff to keep women and babies safe from avoidable harm and to provide the right care and treatment.

Shortages of medical staff on maternity triage and day assessment unit impacted negatively on the safety of care. The service was unable to implement the BSOTS model of triage effectively as there was not dedicated medical cover assigned to maternity triage at the time of inspection. We saw on day assessment unit a GP trainee was covering the service for the morning as there were limited doctors available on the maternity unit. Registrar bleep holders covered gynaecology and obstetrics which created issues around prioritising risk.

The service prioritised medical staffing on the labour ward to keep women and babies safe. The labour ward had 98-hour consultant obstetrician cover on site with twice daily consultant led ward rounds on labour ward. This was in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 4000 to 5000 births a year.

Managers could access locums when they needed additional medical staff. Between April and October 2022 locums covered 201 shifts of which 176 were bank locum staff and 25 where agency staff.

The service always had a consultant on call during evenings and weekends. However, speciality trainee doctors were not always clear on the expectations of when the on-call consultant should attend.

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The service had low medical sickness rates. The sickness absence rate for medical staff within the maternity core service was highest in April 2022 (3.19%) and June 2022 (3.21%). Before April 2022 it was under 1% each month. This was consistently below (better than) the trust target of 3.5%.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection data showed 78% of medical staff in maternity services had received a yearly appraisal.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date. However, records were not always stored securely.

Women's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records.

We reviewed 7 paper records and found staff records were clear and completed. However, the total scores of the modified early obstetric warning score (MEOWS) observation charts were not always completed in 4 out of the 7 records we reviewed.

The trust had plans to transition to fully electronic records by March 2023.

Triage calls taken by experienced midwives are recorded on the patient's electronic record. However, the matron told us midwives covering triage do not always record calls correctly.

Managers audited 10 maternity records a month to monitor the quality of care records. Maternity records audits showed between April and September 2022 showed the service was 100% compliant with records being clear and legible, records being in chronological order and recording of consent. Areas of non-compliance included records being signed and dated with patient name and medical record number on every page.

When women transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. For example, paper records in antenatal clinic were not always locked away. On day assessment unit, staff did not always lock computers, leaving patient information visible to patients.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found some medication used to respond to emergencies was out of date.

Staff followed systems and processes to prescribe and administer medicines safely. Midwives completed medicines management competency testing and the practice development team arranged this. Staff also completed a competency assessment in patient group directions (PGDs a group of medicines that can be administered by midwives without the need for a doctor or nurse prescriber).

Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed were clear and up to date. The service used an electronic prescribing system. midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

The service recognised and managed medicines management risks. For example, the risk of pethidine (a painkiller used in labour) administration errors was recorded on the risk register. A quality improvement project had started at the time of inspection to improve safety of pethidine administration.

Staff did not always manage medicines used to respond to emergencies safely. We found medicines in a 'grab box' on the day assessment unit that were out of date. Staff had access to emergency 'grab boxes' to respond to conditions such as pre-eclampsia, sepsis and cord prolapse. We found equipment in 2 out of 4 boxes of medication were out of date. This included 2 vials of water for injections and 4 vials of calcium gluconate.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women 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. The trust reported 3 maternity serious incidents were report from 1 March 2022 to 17 August 2022. These related to babies born in poor condition or born needing resuscitation.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. This was a 6-month secondment role at the time of inspection.

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

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. For example, obstetric clinical governance meetings showed in May 2022 learning from a serious incident was discussed and staff were reminded of the importance of declaring the urgency of an emergency instrumental delivery. For example, a category 1 emergency delivery is expected to be carried out within 30 minutes.

Managers investigated incidents thoroughly. We reviewed the last 3 serious incident investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified. For example, following a serious incident action were taken to improve staff awareness of the management of pregnant women presenting at the emergency department.

Managers reviewed incidents at the weekly hospital wide serious incident group meeting, chaired by the deputy medical director. We reviewed meeting minutes from 2 of these meetings and found progress on investigations and learning from maternity serious incidents were discussed at these meetings. Women and their families were involved in these investigations and meeting minutes showed where families had declined Healthcare Safety Investigation Branch (HSIB) investigation of an incident that affected them. The weekly serious incident group meeting fed up to the quality and safety committee and up to the trust board.

Managers monitored incidents that were open over 60 days and data showed 6 incidents were overdue for review at the time of inspection.

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Managers regularly reviewed progress with Health and Safety Investigation Branch (HSIB) investigations. There were 3 investigations in progress at the time of inspection.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

Kingston Hospital maternity services were managed as part of the Women, Children and Sexual Health cluster as part of the planned care division of the hospital. Maternity services were managed by a director of midwifery, an obstetric lead and a general manager.

The director of midwifery was supported by a deputy director of midwifery, 3 matrons, a consultant midwife, a governance lead midwife, a safeguarding lead midwife a bereavement and screening lead midwife and 2 practice development midwives.

Matrons often worked clinically on the central delivery suite to ensure staff could take breaks and to mitigate the risks of high acuity and low staffing levels. This was positive as it improved the safety of the unit when staffing levels were reduced. However, this sometimes impacted on matrons' non-clinical duties such as responding to complaints, reviewing incidents, organising staff training and completing appraisals.

The director of midwifery met with the board maternity safety champion every month. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

Vision and Strategy

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

Maternity strategy June 2022 was aligned to the trust strategy and national drivers such as reducing stillbirths and increasing maternity continuity of carer provision. The service had plans to roll out continuity of carer into 50% of community teams by April 2023, with full roll out by 2024.

The maternity strategy set out objectives for ongoing collaboration with the maternity voices partnership (MVP) to co-create information for women and birthing people on a range of topics including, having a caesarean section, induction of labour and continuous fetal monitoring.

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The strategy was developed with the South West London Local Maternity and Neonatal System (LMNS). Key workstreams across the LMNS were, improving smoke-free pregnancies, learning from Black Asian and Minority Ethnic (BAME) women's maternity stories and a maternal medicine hub.

Culture

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

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women's concerns about their care in a less formal way.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. However, leaders did not always respond to complaints in a timely way. We reviewed complaints the maternity service received in the past 3 months complaints and found 6 out of 8 complaints were responded to outside of the trust target timeframe of 25 days.

Leaders had a strong focus on staff wellbeing. For example, we saw senior leaders ensuring staff got breaks. The trust had been selected to work with NHS England on a national health and wellbeing taskforce to improve the health and wellbeing of maternity staff.

Staff we spoke with were consistently positive about working at the hospital and told us they felt well supported and able raise concerns when needed and were part of an inclusive culture. In April 2022 leaders had used the obstetrics and gynaecology clinical governance team meeting to focus on race with an agenda that included updates on national campaigns to promote race equality in maternity care from a national charity and the Royal College of Obstetricians and Gynaecologists. The meeting included time for staff to reflect on how race equality could be improved in the delivery of care at Kingston Hospital.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. There were 5 sub-group governance meetings: maternity risk meeting, maternity clinical governance meeting, perinatal mortality and morbidity meeting, obstetrics and gynaecology consultant meeting and the senior midwifery team meeting. The sub-group governance meetings fed into the maternity triumvirate meeting and the maternity 'big room' quality improvement meeting. These meetings fed into the maternity performance review meeting, cluster performance review meeting, divisional performance review meeting and up to the trust board.

We reviewed minutes of the last 3, monthly triumvirate governance meetings attended by the director of midwifery, general manager for women's and children's and the obstetric and clinical leads. A standard agenda was used to discuss quality, finance, workforce, performance, estates and external visits.

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We reviewed minutes of the last 3 quarterly quality assurance committee meetings. These meetings were chaired by the board maternity safety champion and attended by staff including, the chief nurse, maternity risk manager and director of midwifery. Leaders monitored incidents at these meetings including progress with Health and Safety Investigation Branch (HSIB) investigations.

Leaders monitored perinatal mortality at the quality assurance committee meeting. The September 2022 minutes presented quarter 1 data showing mortality rate was 3.61 per thousand life births which equates to 4 babies over that period. Positively, this is lower than the national average and for assurance the trust was consistently lower than the national average for this metric.

Maternity matrons met every other week to discuss staffing, management issues and themes from incidents. Recent themes are inexperienced staff not recording calls on the telephone triage, and higher risk labouring women in the birth centre.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies including care of the healthy mother and baby, the birth centre standard operating procedure, midwife assessment triage and these were in line with national guidance. Data showed 16 guidelines were overdue for review at the time of inspection, but these reviews were in progress with staff assigned to complete the reviews. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to ensure they were up to date.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Low staffing levels impacting on performance, safety and patient experience was the top recorded risk. The staffing risk was rated as an ‘extreme’ risk and the risk was last reviewed in October 2022 with the risk register updated to reflect that while recruitment was ongoing and new staff were starting in October and November, staff turnover continued to be high. Low staffing levels were mitigated by midwifery managers, matrons and specialist midwives working clinically.

The service monitored incidents and delays to care that related to staffing shortages. The September 2022 safe staffing report to board showed between January 2022 and June 2022 there were 207 staffing ‘red flags’ reported on the incident reporting system.

Managers carried out a comprehensive programme of repeated audits to check improvement over time. The service had a yearly audit programme and participated in relevant national clinical audits. For example, the service participated in the national maternity and perinatal audit and the national diabetes in pregnancy audit. The service collected data on 3rd and 4th degree tears, also known as an obstetric anal sphincter injury (OASI) and held an OASI clinic to follow up on women who have experienced this type of trauma. Leaders reviewed performance in audits at trust and departmental cluster meetings.

Outcomes for women were positive, consistent and met expectations, such as national standards. For example, the perinatal mortality rate was below the national average. Leaders Leaders benchmarked the service against the most recent ‘Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK’ report and the recommendations were discussed at the April 2022 quality assurance committee meeting. Following review of the report leaders proposed to consider the outcomes experienced by Black, Asian and Minority Ethnic and women falling into the most vulnerable groups in more detail.

Maternity

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at board level. The last Ockenden review update to trust board in September 2022 showed the trust was compliant with all 7 immediate essential action and twelve clinical priorities from the 2020 Ockenden report.

Managers and staff used the results to improve women's outcomes. A risk assessment and action plans were created following audits where standards were not met.

Managers shared and made sure staff understood information from the audits and improvement was checked and monitored. Managers monitored audits monthly patient safety and risk management meetings.

The service was accredited by the clinical negligence scheme for trusts, now called the maternity improvement scheme. Recent audits showed the service met all 10 safety standards and the service had met these standards for the past three years also.

Information Management

The service collected reliable data and analysed 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.

Unavailability of maternity data leading to an inability to track trends and monitor safety was a recorded risk on the maternity risk register and rated 'high'. Birth rate data, perinatal mortality rates, post-partum haemorrhage rates and third-degree tear data all had to be extracted manually by the maternity data team. The risk was mitigated by gaining funding for an upgrade to the electronic maternity records system. The full upgrade was anticipated to be completed by March 2023 and the service planned to extract data manually in the meantime.

The data quality failed for 2 of the 12 measures in the NHS Digital maternity dashboard. These measures related to Apgar scores (a standardised scoring system to assess the health of a baby after birth) and women smoking status at time of booking. Data quality in relation to the maternity services dataset had been an issue at the trust over the past few months.

Engagement

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

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity voices partnership (MVP).

The service had good links with the local MVP, and they were involved in the governance of the service. The service had plans to improve the quality of information provided to the women, especially about induction and caesarean birth, and work had started to involve local women in this.

The CQC Picker Maternity Survey results for 2021 showed, in comparison to other trusts, Kingston Hospital NHS Foundation Trust scored about the same for 34 questions, 'somewhat better than expected' for 4 questions, better than expected for 10 questions, and much better than expected for 2 questions.

Maternity

The NHS staff survey results in maternity were slightly lower than the organisation average results in all question themes.

The 2021 General Medical Council Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

The board safety champion ran open forums both virtual and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.

Learning, continuous improvement and innovation

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

Staff were supported to complete quality improvement projects. For example, staff presented audit data as part of a quality improvement project on the effectiveness of epidural analgesia (pain relief) in labour at the May 2022 obstetric governance meeting. Following the audit, staff planned to work with the local maternity voices partnership to gain feedback on people's experiences of epidurals and to update the pain measurement tool.

The service was part of a national trial called the 'Opti-breech' trial which looked at the success of vaginal breech births, this is good practice. The purpose of the study was to improve safety and provide accurate evidence-information on breech birth to women.

The service had established good links with urogynae and had a specialist perineal midwife to support the ongoing care of women with perineal trauma.

The service had a 'learning from incidents midwife' in post who was developing innovative ways to share learning with staff. This midwife was developing innovative ways to engage staff in learning from incidents and being aware of risks in the service. They had created videos, newsletters and private social media groups to share learning with staff. For example, they created a video showing how a wet incontinence pad can lead to pressure sores. They had also created a quiz to improve staff awareness on the process for taking newborn bloodspot samples in response to an increase in incidents of inadequate samples being taken.

Outstanding practice

We found the following outstanding practice:

- Maternity services had a learning from incidents midwife who was working to share learning from incidents in creative ways through use of videos and social media.

Maternity

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

MUSTS

The trust must ensure that:

- staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c)
- staff complete regular skills and drills training. Regulation 12(1)(2) (c)
- the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
- staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
- medical staffing for maternity triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1))
- staff have access to appropriate safeguarding supervision to carry out their duties Regulation 18 (2) (a)

SHOULDS

- The trust should ensure that paper and electronic records are stored securely. Regulation 17 (2) (d)

Our inspection team

During our inspection of maternity services at Kingston Hospital we spoke with 25 staff including maternity leaders, midwives, doctors, midwifery support workers and administration staff.

We visited all areas of the unit including central delivery suite, the birth centre, maternity triage, day assessment, Worcester postnatal ward and Thameside postnatal. We reviewed the environment, 7 records and maternity policies while on site. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

The inspection team included 3 CQC inspectors and 2 specialist advisors with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

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