East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Inspection report

St Peter's Road
Margate
CT9 4AN
Tel: 01227766877
www.ekhuft.nhs.uk

Date of inspection visit: 21 to 22 July 2021
Date of publication: 16/10/2021

Ratings

Overall rating for this service

Requires Improvement

Our findings

Overall summary of services at Queen Elizabeth The Queen Mother Hospital

Requires Improvement 

We carried out an unannounced focused inspection of the maternity services at East Kent Hospitals University NHS Foundation Trust because we received information giving us concerns about the safety and quality of maternity services.

To get to the heart of patient care, we visited the maternity units at the Queen Elizabeth the Queen Mother Hospital on 21 July 2021. We also visited the community midwifery services at Buckland Hospital on the 22 July 2021.

As this was a focused inspection, we only inspected three of the key questions in maternity services (safe, effective and well led).

Focused inspections can result in an updated rating for any key questions that were inspected if we have inspected the key questions in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

We inspected maternity care throughout the unit so we could get to the heart of the patient experience. During the inspection, we needed to understand the patient journey and make sure that women and babies were kept safe from harm and that staff were supported with their training and decision making.

How we carried out the inspection

One CQC inspector led the inspection supported by an experienced obstetric specialist advisor and a midwifery specialist advisor.

On the day of the inspection, we visited five key areas of the maternity unit; the delivery suite, antenatal triage, maternity day care the antenatal/postnatal Kingsgate ward and the community midwifery teams in Dover.

We spoke with over 27 staff including executive staff, service leads, midwives, medical staff and maternity support workers, consultants, registrars, junior doctors and student midwives.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this does not include all our key lines of enquiry (KLOEs). As a result of this inspection ratings for this service remain unchanged. The rating stays as requires improvement.

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

Maternity

Requires Improvement ● →←

Our rating of this service stayed the same.

- 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. Women and babies were not always visited and reviewed at home for a 'first visit' after discharge.
- Staff were not consistently monitoring mothers who smoked.
- The service did not always control infection risk well. Staff did not record that birthing pools were cleaned after every use. Not all hand wash sinks in day care were dedicated for this reason. Walls in the triage area were cracked, making them difficult to clean.
- The design of the premises and facilities did not always protect women's privacy and dignity. Women who experienced bereavement, laboured and gave birth on the delivery suite. Not all rooms on the labour suite were ensuite so women shared bathroom facilities.
- Not all staff had completed training in key skills, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse.
- Leaders were not always aware of the risks, issues and challenges in the service. Leaders did not operate an effective governance process to continually improve the quality of the service and safeguard the standards of care. There was a lack of oversight of the community services, including a lack of input at the daily safety huddles.
- The service did not have an open culture where staff felt confident raising concerns without fear. Not all staff felt respected or valued and rarely felt supported.
- Medicines were not always stored within recommended temperatures.
- Not all staff receive adequate induction when working in an area they are not familiar with, and some staff reported working outside of their competence.

However;

- Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They 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.

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement.

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff, however not everyone had completed it.

The mandatory training was comprehensive and met the needs of women and staff. Training was planned and organised through the trust's faculty of multi professional learning in maternity. The trust had developed a multidisciplinary learning environment that focused on all aspects of obstetric and midwifery skills to deliver safe, emergency care. During the COVID-19 pandemic, face to face sessions were postponed and the trust was beginning to restart multi-professional face to face sessions.

The practice development lead midwife monitored mandatory training and alerted midwifery staff when they needed to update their training. The practice development lead midwife used a standardised digital tool to monitor training compliance. Staff received alerts when they needed to update their training. Because of the impact of COVID-19 the trust had created a training recovery plan. This meant the trust had oversight on gaps and shortfalls and created actions plans with time frames to ensure that all staff were trained to safely care for mothers and babies.

Staff received mandatory training but not everyone kept up to date. Data showed there were 19 mandatory modules for staff to complete. Seven of the 19 mandatory modules met the trust target of 90%. Out of the remaining 12 mandatory modules, we saw compliance ranged between 12% and 89%.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Data showed as of June 2021, 92% of staff had completed diversity awareness training. However, only 12% of staff had completed dementia training.

Cardiotocography training was an essential part of staff training to make staff meet the needs of women and their unborn child. Data supplied showed that 95.7% of staff had completed this training.

Multi-professional maternity emergencies training was mandatory for all maternity staff. Data showed 100% of community midwives and 94% of midwives who worked at the acute site, had completed this training in the previous 12 months. In addition, 92.8% of medical staff had completed this in the last 12 months. However, only 77.1% of acute maternity support workers and 83.3% of community maternity support workers were up to date with this training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all staff were up to date with safeguarding training. They knew how to recognise, and report abuse and they knew how to apply it.

Midwifery staff received training specific for their role on how to recognise and report abuse. Midwives were trained to level 3 safeguarding children. Data showed that 91% of midwives at QEQM and 93% of community midwives had completed this training. This was better than the trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse, however not all staff were up to date. Data showed 63% of medical staff had completed safeguarding children level 3 training. This was worse than the trust target of 90%. However, 100% of medical staff had completed safeguarding children level 2 training.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave us examples of good communication and working relationships with GP's and health visitors. In addition, community midwives spoke about working with migrant or refugee women and babies and had good relationships with social services and those working on the boarder.

However not all staff were up to date with safeguarding vulnerable adults training. Data showed as of June 2021, 83% of staff had completed safeguarding vulnerable adults training level 2. This was slightly worse than the trust target of 90%. However, 100% of staff had completed level 1.

Women using the service were routinely asked about domestic abuse. Eight patient records showed women were asked about domestic abuse in line with the National Institute for Health and Care Excellence (NICE) Domestic violence and abuse guidance (2016).

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Midwives knew how to access policies and referral forms electronically. Staff knew who the safeguarding leads for the service were and how to contact them. Community midwives said they had access to safeguarding leads and advice because there were four safeguarding midwives working at the trust.

There were systems in place to notify staff of women or families who are subject to a child protection or child in need plan. The trust had access to an online child protection information sharing programme to enhance the safeguarding processes and sharing of information. The system checked the national database to identify any pregnant woman who may be on a pre-birth child protection plan. Prior to community midwives attending a home birth, the midwives at the acute site will check the child protection information sharing system. If there are any potential issues, they will call a second midwife to assist.

There was a lack of oversight of safeguarding issues or concerns for the community service. There was no daily safety huddle in the community or input into the cross-site safety huddle at lunch time. In addition, lack of staffing meant first-time face to face visit, following birth. This meant there were missed opportunities to see the home environment in terms of highlighting safeguarding issues. We raised our concerns following the inspection and managers told us they would re-introduce first home visits in line with national guidance.

Women not engaging or not attending antenatal appointments were highlighted to the lead safeguarding midwife and the safeguarding teams. Staff working in triage gave us examples of how they managed this including completing a safeguarding referral or liaising with police if necessary.

Staff followed the infant abduction procedure; babies were labelled at birth and access to all areas was via locked doors. This was to keep babies safe.

Cleanliness, infection control and hygiene

The service did not always control 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 and department areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean. Furnishing were visibly clean and intact. However, not all walls were intact. For example, in the triage area we found walls had cracks, holes and scuff marks. Non intact surfaces such as floors and walls can harbour dirt and dust and make cleaning difficult.

Maternity

Staff cleaned equipment after patient contact. Equipment was visibly clean. Staff had a good understanding of responsibilities in relation to cleaning and infection control. Disinfection/detergent wipes were available to clean equipment between patient contact. Good supplies were seen across all areas visited.

The acute site had three birthing pools. Birth pools were cleaned after use, staff followed a decontamination procedure for birthing pools. However, staff did not record that the birthing pools were cleaned after every use. This meant there was no assurance that the pools were cleaned in line with protocol after every use and were safe for women to use.

Disposable curtains were in use. Each curtain had a label showing the date it was changed. We looked at 12 and saw all were changed in the last six months.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, such as gloves, aprons and masks were readily available for staff, to ensure their safety when performing procedures. Staff wore PPE correctly in line with trust policy.

There were sufficient hand washing sinks and alcohol-based hand sanitiser within all areas of the service we visited. Soap and paper handtowels were available next to sinks. However, we found not all hand wash sinks were dedicated for this reason. We found in the day care area that staff were washing up cups in hand wash sinks. Hand washing sinks should be dedicated for hand washing to prevent the risk of cross infection.

Staff washed their hands with soap and water or used the alcohol-based hand sanitiser, in line with the World Health Organization's 'five moments of hand hygiene'. Staff in clinical areas were bare below the elbow. However, data showed that only 44% of staff were up to date with their hand hygiene training.

The service had timely COVID-19 testing protocols for effective decision making. All women were asked standardised questions about COVID-19 as part of the risk assessment process. This was documented in the medical records. If a woman presented with any symptoms, they isolated them from other people.

All women were tested for COVID-19 on admission, and on day three if still an inpatient. Staff we spoke with were aware of when and how to test women for COVID-19, and what to do in the event of a positive result. Staff did not report any concerns about timeliness of results. There was a daily tracking sheet, to see what tests were taken and any results. This also helped with any contact tracing that may need to be undertaken in the event of a positive result.

Women could have a birth partner present during labour. They required this person to have had a negative COVID-19 test, where possible, 24 hours prior to attending. Visitors were identified with a 'pink' wristband. Where people were not able to show a negative result, staff undertook a rapid test, to check for COVID-19.

Staff testing for COVID-19 was embedded practice. All patient facing staff undertook bi-weekly COVID-19 lateral flow device tests (a basic self-test procedure). If a member of staff had a positive result, they arranged a polymerase chain reaction (PCR) test and isolate until their result were returned.

There were clear guidelines for staff to follow to screen patients for the presence of healthcare associated infections (HCAI). Staff screened women, who had caesarean sections for Methicillin resistant *Staphylococcus Aureus* (MRSA). MRSA is a type of bacterial infection, that is resistant to many antibiotics and has the capability of causing harm.

Maternity

The service generally performed well for cleanliness. There were dedicated housekeeping staff responsible for cleaning all areas of the wards and departments we visited. Data showed between March and June 2021, compliance with cleaning standards varied between 88.1% and 99.3%. We saw most scores achieved were greater than 95% for the weekly audits. Where areas did not achieve this, it was unclear from the information provided by the trust what corrective actions were taken.

Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of pseudomonas and legionella bacteria. *Pseudomonas* infections are caused by bacteria that's commonly found in soil, water, and plants. *Legionella* bacteria is common is natural water sources. Both can cause a serious lung infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe, but did not always ensure their privacy and dignity was maintained. All equipment used in maternity was well maintained and kept people safe, staff were trained to use them. Staff managed clinical waste well.

The service did not have suitable facilities to meet the needs of women's families. Women's privacy and dignity was not always maintained. The labour suite had eight rooms; one was a high dependency room. The room was large and had a baby resuscitaires in it. A baby resuscitaire is a device which combines a warming therapy platform along with the components needed for clinical emergency and resuscitation.However, the rooms were not all ensuite and some had bathrooms which were shared by the room next door and was accessed by an adjoining door. This meant not all women had complete privacy during or following labour.

The bereavement room was away from the delivery suite and was well thought out. It provided a homely environment that was non-clinical. However, women who had a bereavement, laboured and gave birth on the delivery suite. This meant women could hear babies cry and celebrating families.

The design of the environment did not always follow national guidance. The environment on the delivery suite and the birth centres were not always homely and welcoming. They were not decorated in a sensitive way. They were clinical, and included bare walls, stark lighting and no home from home approach. This environment did not fully comply with Department of Health guidance: Children, young people and maternity services Health Building Note 09-02: Maternity care facilities. A review of the privacy and dignity of women on labour ward at the hospital was undertaken in October 2020. The review recommended follow on actions to improve the privacy and dignity of women, including ordering of new screens, and improving the decoration to create a more 'homely' environment.

There was secure access to the midwifery led unit and staff at the reception desk monitored who had access to the unit to prevent unauthorised access.

Staff carried out daily safety checks of specialist equipment. The unit had standardised check lists of emergency equipment. We looked at three resuscitation trolleys and three baby resuscitaires, which were well stocked and checked twice daily at the beginning of each shift. Staff used a check list to record that equipment was in working order and that single use items were in date. Once equipment was checked, the staff member had to date and sign the list. Any items found to be faulty were set aside and labelled, so that they were not used in error.

Staff disposed of clinical waste safely. Controlled substances hazard to health (COSHH) were stored correctly. Bins were colour coded, and sharps bins were dated and available at the point of patient care.

Disposable equipment for once-only use was safe and fit for purpose. In all clinical areas we visited, we checked disposable pieces of equipment, such as needles and syringes. We saw they were all sealed and in date.

Community midwives had their own equipment. All community midwives carried a home birth bag which had recently been reviewed and standardised. This meant community midwives could open the bags and locate what they needed without delay. There was a separate neonatal resuscitation bag, which community midwives collected prior to attending a woman at home.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Women were risk assessed at every antenatal appointment or after any incident of unplanned care. For example, we saw risk factors such as living conditions, comorbidities, body mass index or those aged over 35 were used to identify those at risk of poor outcomes.

Staff used a standard operating procedure to assess and review women from black, Asian and minority ethnic groups (BAME) in response to the Royal College of Midwives and the Royal College of Obstetricians report, 'Coronavirus (COVID-19) infection in Pregnancy (2020)' which identified that these women were at five times greater risk of having poor outcomes. The trust monitored ethnicity via the booking assessment and at each point of the care continuum. Women whose first language was not English had access to interpreting services and offered women with darker skin vitamin D in line with national guidance. Other risk factors like obesity, diabetes, social deprivation and maternal age were factored into the risk assessments and women assessed as high risk were referred for obstetric assessments.

Antenatal scans were offered throughout pregnancy. The service recorded fetal growth on a chart to make sure it was as expected for the mother's gestation. Any differences in standard growth were referred to the hospital for extra scans and an obstetric review. In addition, fetal movements were recorded at each antenatal visit from 25 weeks. We looked at eight records and found they were fully completed.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Lead midwives and one consultant were identified to care for women with chronic mental health problems. They liaised with mental health teams and social care to make sure women with mental health problems received the care they needed. We looked at eight sets of records and found a mental health assessment was completed in all eight.

A triage service was open 24 hours a day seven days a week for women who were experiencing pain or symptoms from 16 weeks of pregnancy. If women had concerns about their pregnancy before birth or postnatally, they could contact the maternity triage. The service had pathways of care for specific conditions which triage midwives followed. Midwives completed an initial assessment using their colour coded risk rating system; red for high risk, amber for moderate risk and green for normal. This made sure that those at high risk were prioritised.

Maternity

Staff shared key information to keep women safe when handing over their care to others. When women moved from one area to another, for example from triage to labour suite, there was a formal process for staff to follow to make sure all relevant clinical information was handed over. The 'SBAR' tool which stands for situation, background, assessment and recommendation, is a tool which is commonly used during the handover of care for patients. The service told us they did not audit compliance with the use of the SBAR tool, so lacked oversight on the effectiveness of the tool.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS). MEOWS is a nationally recognised, competency-based tool to trigger escalation. We looked at eight records and saw they were completed fully and scored correctly. There was no difficulty in obtaining medical support in the case of a deteriorating woman or baby.

Staff worked well together in the event of an emergency. During our inspection, we witnessed an emergency delivery. We saw a safe delivery that demonstrated safety processes were embedded. However, instructions were not always clear, but there was a meaningful brief, stop moment and debrief with all staff from the delivery. Both consultants and the team worked together to ensure safe delivery.

A balloon fetal head elevation device for use in cesarean sections carried out in the second stage of labour was not available when requested. This is a device which is inserted into the vagina and placed beneath the head of the baby and then inflated to help lift their head and dislodge it from the pelvis before commencing the caesarean section.

Delivery suite staff checked fetal wellbeing via handheld dopplers for low risk women or cardiotocograph (CTG) machines for women needing closer monitoring. The service used central electronic fetal monitoring which was accessible in the delivery rooms and within the handover rooms, so that the co-ordinators and doctors observed fetal wellbeing.

Based on national recommendations and learning from serious incidents, the trust had implemented measures to ensure the safety of babies during labour. For example, a fresh eyes and fresh ears approach to CTG interpretation. We looked at eight records where CTG was used and saw the documentation at the start, during and end of the monitoring met NICE (2017) Intrapartum care for health women and baby's guideline. However, 'fresh eyes' was only documented in six out of the eight records.

Staff knew about and dealt with any specific risk issues. Venous thromboembolism (VTE) risk assessments were recorded at booking, following birth and at every admission. VTE is a condition where blood clots develop in a vein. We looked at eight VTE assessments and found they were fully completed.

Staff followed standard operating procedures for women who chose to have a caesarean section. Women attended a pre assessment clinic where they had a review of their health, routine blood tests Doctors explained the procedure and gained consent prior to surgery. We looked at four records of women who went to obstetric theatres and saw consent gained prior to surgery, risks explained, and forms fully completed.

Staff completed a theatre checklist for women transferred there during labour for invasive procedures which included a caesarean section. The checklist followed World Health Organisation's (WHO) 'Five Steps to Safer Surgery Checklist'. In addition, two staff were responsible for counting swabs and making sure all instruments used accounted for. We looked at four records of women who went to obstetric theatres and saw the checklists and swab, instrument counts were completed in full.

Maternity

Staff risk assessed newborn babies at birth using pro-forma which included; maternal history, babies APGAR scores, mode of delivery, and weight. The Apgar score describes the condition of the newborn infant as soon as it is born. Staff completed a neonatal observation early warning score and included this in the assessment. Midwives calculated the scores to determine if the baby were high, moderate or low risk to place them on the right care pathway and the correct monitoring and care provided.

Community midwifery teams did not visit all new mothers and their babies at home, because they adopted 'telephone' assessments. This was not in line with national guidance. This meant there could be delays in identifying mothers and babies whose condition deteriorated during the post-natal period specially jaundice in newborn babies and infants. Jaundice is a condition that affects the function of the liver and can lead to long term disability.

Staff were not consistently monitoring mothers who smoked in line with NHS England (2019) saving babies lives care bundle. Carbon monoxide monitoring had stopped during the COVID-19 pandemic but was recently re-introduced. We saw for June 2021, this had only been undertaken on 17.7%, of women and was below the target of 69%. Also, we found that some women's care records had no evidence of them being asked routine smoking questions during pregnancy. The monitoring of smoking during pregnancy is important because smoking is known to contribute to stillbirth. The trust recently undertook a rapid review of stillbirths across the region and found that 40% of women who experienced a stillbirth between 1 November and 31 December 2020 smoked.

Managers made sure staff used the obstetric anal sphincter injury (OASI) care bundle which is a set of interventions to reduce the risk of perineal trauma.

Shift changes and handovers included all necessary key information to keep women and babies safe. We saw a handover on the post-natal ward. The handover was structured and held in a quiet private room, with no interruptions. We found women were always referred to by their names and the full history was given, including physical, psychological and emotional wellbeing. Midwives were allocated, where possible, to women they knew for continuity of care. The midwife in charge checked that staff were 'all happy' with the allocation prior to leaving the handover.

The trust had completed a risk assessment for evacuation of the pool in the event of maternal collapse and new and existing staff had simulated training to reinforce this. The unit had an 'evacuation of the pool' kit which was readily available.

Midwifery 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 skill mix but were limited to the resources available. Community midwifery staff were regularly used to fill shifts.

The service did not always have enough midwifery staff to keep women and babies safe. Staffing issues was the main concern voiced by staff we spoke with. The service had low vacancy rates. Data showed the service had a 3.1% vacancy rate for June 2021, and an average of 1.5% for the previous 12 months.

The service had high sickness rates. The current sickness rate was 7.5% for midwives and 5.5% for maternity support workers. The service did not display planned (required) and actual staffing levels allocation.

The midwifery led unit was currently closed due to staffing issues. This was due to a combination of sickness (long and short term), and maternity leave.

Triage staffing had been recently reviewed. Previously the triage was staffed by two band six midwives and one maternity support worker for a day shift and one band six and one maternity support worker at night. Following the review, a band seven midwife was being permanently allocated to triage. This would improve senior oversight and clinical decision making within the unit.

The number of midwives and healthcare assistants matched the planned numbers. During our inspection, most areas were staffed as planned except for one midwife who was absent from the night on call rota. Staff told us this was rare to have this level of staffing with midwives usually being required to support from the wards, labour suite and the triage unit.

Managers could adjust staffing levels daily according to the needs of women in labour. A nationally recognised acuity tool was used to review staffing levels within the service. The tool risk rated staffing levels through the day and highlighted periods of unsafe staffing. However, it did not monitor all activity undertaken by midwives, to provide accurate guide for decisions about staffing requirements on the ward or departments.

Data showed between July 2020 and June 2021 one to one care was achieved in 100% of deliveries, except for May and June 2021, where they achieved one to one care in 93.3% of deliveries. This meant the service had a rolling 12-month average of 99.9%, of one to one care during delivery

Managers limited their use of bank and agency staff and requested staff familiar with the service. Community midwifery teams were included in the maternity escalation plan, however the impact this had on their service had not been taken into consideration. Community midwives reported it was common practice for them to back fill shifts at the acute sites, via their on-call rota. Data showed the number of times community staff were called to cover the acute site had increased from five in February 2021 to 59 in June 2021. This meant the service did not have enough staff to keep women and babies safe and may be exposed to harm as staff did not have time to provide appropriate care.

The impact on safety was not routinely assessed and monitored when making changes to the service or staff. Community staff told us they worked their normal contracted hours, and then could be called to cover a shift at an acute site for the entirety of their on call. This resulted in short notice cancellations of clinics and appointments. There was no process for relieving community midwives called in at night to support the unit. The trust confirmed there was no recent risk assessment into community midwife's workload.

After the inspection, we raised our concerns about staffing levels with the trust. As a result, the trust suspended their homebirth service, so they could redeploy homebirth midwives to work in the maternity unit and keep mothers and babies safe whilst completing a review of community midwifery working hours.

At the time of our inspection, the service had recruited 10 newly qualified midwives, who were due to start in September 2021. The majority of these new staff members were newly qualified midwives that would require a period of preceptorship and supernumerary status. This was hoped to improve staffing numbers across the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Maternity

The service had enough medical staff to keep women and babies safe. There had been no significant change in the medical staffing for the maternity services. The hospital consultant cover was 97.5 hours per week, Monday to Friday from 8am to 10:30pm, and Saturday to Sunday from 8am to 8:30pm. This was in line with the safer childbirth recommendations by the Royal College of Obstetricians and Gynaecologists (RCOG) for the minimum number of hours of consultant presence on the labour suite per week.

Medical staffing mostly matched the planned number. At the time of our inspection, records confirmed that the current budget for medical staff was 45 whole time equivalents, although there was currently a shortfall of 1.5 whole time equivalents.

The service always had a consultant on call during evenings and weekends. There was a consultant on-call from home available 24 hours a day, seven days a week. The on-call consultant and on call maternity manager dialled into the 10.30pm safety huddle each evening.

Anaesthetists were available 24 hours a day, seven days a week and included extra sessions for elective caesarean sections on Monday's, Tuesday's, Thursday's and Friday's.

There was a dedicated named doctor allocated to the triage area Monday to Friday 9am to 5pm. Staff told us this made a huge impact as previously they had found it a challenge to access senior medical staff to review women within the unit which could lead to long waits for women and difficulty in managing the numbers of women within the small area they worked in.

Morning handover was attended by doctors, the midwife shift co-ordinator and the paediatric lead for the day. We saw there was a structured approach to the handover and confidentiality was always respected. There was good clinical discussion around a complex case, who then required emergency delivery.

Daily cross-site huddles were attended by medical staff, midwives and paediatric staff. During these calls, the capacity of the unit was discussed, as well as any staffing issues and practice updates. However, we saw key staff were late or not there for the whole handover.

The service had consultant leads for perinatal mental health, diabetes, fetal medicine, and a lead for fetal monitoring during labour.

Managers could access locums when they needed additional medical staff. The service had low use of locum staff, and the locums that were recruited by the trust were given a full induction. Records showed between July 2020 to July 2021, 11 locums were used. There was a procedure and checklist to make sure locum doctors were orientated to the area they worked in and trust policies.

Records

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

Women's notes were comprehensive, and all staff could access them easily. The service used a combination of paper-based and electronic records. Community midwives could access the digital care records in the community.

Women and newborn babies were given a discharge summary of their care during their stay before they left the unit. GPs and health visitors were sent the information separately, so they could make any follow up appointments with women.

Mothers were given a personal child health record on discharge. Health professionals used the record to record information on the baby's birth and health, including feeding assessments, new-born checks and new-born hearing screening.

Records were stored securely. Paper records were stored in locked cabinets. The electronic patient systems were only accessible through password protected systems to authorised staff. Staff could view and share patient information to deliver safe care and treatment in a timely and accessible way.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always stored within recommended temperatures.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We looked at the prescription charts for eight women. All were signed and dated by the prescriber. Charts documented patients' allergies, and there were no omissions of medicines on the charts.

There were processes for the stewardship of antimicrobials (drugs used to treat infections due to bacteria, viruses and fungi). We looked at three prescription charts for women who were prescribed antimicrobial treatment. All prescriptions were fully completed, including dose, duration and indication.

Staff followed current national practice to check women had the correct medicines. We saw before medication was administered to women staff checked their name, date of birth and if they had any allergies. We saw they waited with the women while they took the medication before signing as given. However, there were times when midwives worked in areas, they were unfamiliar with. This meant midwives gave medicines they were not used to or only administered occasionally.

Medicines were stored in locked cupboards in locked rooms. There was a system in place to check for out of date medicines. Pharmacy collected and disposed of unused, expired or medicines that were no longer needed.

Controlled drugs such as morphine (a group of medicines liable for misuse that require special management), were kept securely in suitable double locked cupboards. The cupboards were bolted to the wall. The midwife in charge held the keys and only authorised staff had access to these.

Medicines were not always stored in line with the trust's policy. Medicines were not always stored within recommended temperatures. Appropriate medicines were stored in dedicated medicine fridges and records showed daily checks were undertaken. We checked the records for the ambient temperatures of the room where medicines were stored, which showed temperatures often exceeded recommended limits. Actions taken to correct this, had not been effective. If medicines are not stored at the correct temperature, they may not work in the way they were intended and pose a potential risk to the health and wellbeing of the people receiving the medicines.

There were systems and processes in place for administering, transporting and recording of medicines and medical gases given in the community. Medicines were transported in a 'home birth bag'. All medicines were in date. Midwives told us all medicines were checked weekly and replaced monthly or following use.

Maternity

Community midwives transported medical gases safety. Medical gases such as Nitrous Oxide, a gas used to control pain during birth, were stored safely in a locked room. Community midwives collect the medical gas from the storeroom, when they were notified a woman had gone into labour. The medical gas was transported securely in a bag in the boot of the community midwife's car.

Incidents

The service managed safety incidents well. Staff recognised incidents and near misses, but did not always report incidents. Managers investigated incidents and shared lessons learned 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.

The service had made improvements since our last inspection on how they managed patient safety incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients information and support. Managers made sure that actions from patient safety alerts were implemented and monitored.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. The service used a standardised reporting tool that could be accessed online, and staff knew how to access it. Staff knew what incidents to report and how to report them but did not always take time to report them, particularly around staffing issues. Between January and June 2021, there had only been four incident reports for unsafe staffing. Staff felt continually reporting short staffing had not improved the situation, so they had stopped reporting this.

A lead midwife was appointed to oversee the reporting and investigation of all cross-site risks. They were responsible for auditing data, reviewing policies, meeting key performance targets, allocating investigations and feeding back concerns to the lead for risk and governance.

Staff reported serious incidents clearly and in line with trust policy. The service reported serious incidents relating to maternal death, intrapartum stillbirth and early neonatal death. In accordance with the serious incident framework 2015, the trust reported 21 serious incidents in maternity which met the reporting criteria set by NHS England between July 2020 to June 2021. This was slightly above the expected rate of 19. Reviews and actions were ongoing.

Managers investigated incidents thoroughly. However, there was a backlog of incidents. Data showed there were 210 maternity incidents; one was categorised as moderate harm and one was categorised as abuse. Incidents were categorised using national the serious incident framework (2015) guidelines to determine the level of harm. As of June 2021, data showed for the reporting period the service had 287 open incidents. The trust did not provide a rationale for the backlog, or an expected timeline for completing the investigations.

The maternity service reported no never events. Staff told us that managers shared learning from incidents with their staff and across the trust. This included posters which displayed the 'message of the week'. Staff told us of changes to practice as a result of an incident and found the posters a useful reminder.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Families were told when they were affected by an event where something unexpected or unintentional had happened. Families were involved in the investigation, to make sure that the family's voice was represented and that any questions heard and responded to within the investigation report

Maternity

Staff received feedback from investigation of incidents, both internal and external to the service. However, some staff reported this was a generic email, and did not always explain the outcome of the incident investigation.

Staff had the opportunity to meet to discuss the feedback from incidents and look at improvements to patient care. Incidents were discussed at weekly risk meetings, but due to lack of staffing they told us they did not always get the chance to attend.

Serious incident deep dive reviews were completed to identify trends and learning. Reviews included the stillbirths, babies who had oxygen restrictions during childbirth and were sent for a treatment called cooling and baby deaths.

The service reported serious incidents, where appropriate to the Healthcare Safety Investigation Branch (HSIB).

Managers debriefed and supported staff after any serious incident. Trauma Risk Management (TRiM) is a welfare process the service used to assess the wellbeing of staff. Staff were provided with TRiM training and managers held TRiM sessions following serious incidents.

Maternity Dashboard

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

The maternity dashboard is a clinical performance and governance score card to monitor and help to identify patient safety issues in advance so that timely and appropriate action can be introduced to ensure a woman-centred, high-quality, safe maternity care. The tool uses a red, amber and green (RAG) traffic light system to measure performance against agreed parameters. It covered categories such as clinical activity, workforce, clinical outcomes, and complaints.

We saw that the service had a RAG rated dashboard which identified compliance with safety performance indicators and clinical outcomes by site or ward. However, although we saw that key performance indicator data was collected, the results were not displayed, and not all staff had access to the dashboard.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

The maternity service had clear performance measures which were effectively monitored. These included the maternity dashboard. The maternity dashboard parameters were presented in a format to allow it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service participated in relevant national clinical audits. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This allowed the service to benchmark performance against other providers and national outcomes.

Maternity

Outcomes for women were mostly positive, consistent and met expectations, such as national standards. The care group implemented the Avoiding Term Admissions to Neonatal Units (ATAIN) model of monitoring care of newborn babies. Midwifery managers and neonatal doctors reviewed all term admissions, so that themes and trends could be found. Records confirmed that the 12-month average for the trust was 3.5% which is below the national target of 5%.

Managers submitted outcome data to the National Maternity and Perinatal Audit (NMPA). The trust reviewed stillbirths and neonatal deaths over the past seven years to make sure lessons had been learned and outcomes improved. Records confirmed that the neonatal death rate of 1.15 per 1,000 births was well within national expectations. The stillbirth rate was 3.26 per 1,000 higher than the national average, although this was lower than five out of the seven years.

Managers shared and made sure staff understood information from the audits. A recent audit of women's mental health, found that there had been a significant (24%) increase in women presenting for care with mental health problems. The audit looked at care records throughout pregnancy and birth and noted that although 100% of midwives ask routine questions about women's mental health at each appointment not all medical staff did. Because of this the trust had implemented some actions, which included updating the Perinatal Mental health guideline and including mental health training on the mandatory program.

However, managers and staff did not always use the results to improve women's outcomes. Caesarean section deliveries accounted for 41.9% of births each month, this was higher than the trusts target of 32.7% and the national average of 29.6%. Of these, emergency caesarean section accounted for 31.8% of births each month and elective caesareans accounted for 19.7%.

Data was collected to support higher risk women at all booking appointments. This included women's ethnicity, postcodes to highlight social deprivation or other risk factors such as a high body mass index. Records confirmed that only 1,950 (34%) pregnant Black, Asian and Ethnic Minority (BAME) women, out of 5,750 had a medical risk assessment completed at every appointment. It was unclear what actions have been put in place to improve this.

Managers shared and made sure staff understood information from the audits. Outcomes were shared with staff at meetings, safety huddles or via email or posters. During inspection, we saw posters showing their ATAIN performance in clinical areas which we saw during our inspection, along with 'message of the week'.

The service was accredited by the Clinical Negligence Scheme for Trusts (CNST).

Competent staff

The service made sure staff were competent for their roles. Manager appraised staffs work performance and held supervision meetings with them to provide support and development. However, not all staff receive adequate induction when working in an area they are not familiar with, and some staff reported working outside of their competence.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The trust offered all newly qualified staff a preceptorship programme. There were link midwives for students and an orientation pack was developed for them. This was well received and was currently being reviewed for use with new doctors to the area. Student midwives we spoke with felt well supported by midwives, who were approachable and knowledgeable.

Maternity

Managers gave all new staff a full induction tailored to their role before they started work. New staff received a comprehensive induction with clearly identified support and supervision to achieve specific knowledge and skills. However, staff who were asked to work in areas they were not familiar with reported having a poor induction or orientation, leaving them underprepared which affected their ability to perform effectively and safely.

Midwives told us they worked outside of their skills and experience. The trust reported community midwives called in to cover at the acute sites were given a choice of where they worked. All community midwives we spoke with told us this did not always happen; they were often asked to care for high risk women. Staff told us if they expressed concerns about working outside of their competence this was dismissed and not listened to.

Community midwives confirmed they were given no extra training or support to work at the acute sites. We saw in the May 2021 governance meeting minutes there were plans to rotate community midwives into the acute setting. None of the staff we spoke with had rotated into the acute site to develop skills, competence and confidence in this area.

The clinical educators supported the learning and development needs of staff. The service had 2.6 whole time equivalent (WTE) practice development midwives. They were responsible for organising, implementing, and reviewing training packages based on the most recent evidence and in response to serious incidents.

In addition, the service had 14 professional midwifery advocates (PMAs) and one trainee. PMAs are experienced midwives with additional training, to allow them to support the practice and professional development of midwives.

Each professional midwifery advocate had a caseload of 30 midwives, who they meet with once a year to complete revalidation and restorative clinical practice to support staff following an incident. Each professional midwifery advocate were allocated 7.5 hours a month to undertake this role.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attended team meetings and forums to share learning. Staff updates were shared through email notification and posters.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us developmental opportunities were encouraged and supported. The service was keen to develop and nurture staff interests and skills. Some midwives were given additional support and training for specialist roles, such as diabetes, fetal wellbeing, infant feeding and bereavement. Band 6 midwives and above were encouraged to undertake the NHS newborn and infant physical examination training.

The trust had a band 7 development programme to enhance shift leadership across the trust and help senior staff make decisions and manage workloads effectively.

Managers supported staff to develop through yearly appraisals of their work which benchmarked against the visions and values of the trust.

Maternity support workers had the opportunity to attend training for specialist roles. For example, there were maternity support workers with specialist training in breastfeeding, tongue tied, and bladder scanning.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Clinical leads attended a clinical leadership development programme, working with the faculty of medical leadership management through association with consultant staff to review and strengthen medial appraisal.

Maternity

Women were risk-assessed for gestational diabetes and offered glucose tolerance testing in line with NICE (2015) on Diabetes in pregnancy guideline. There was a link midwife for diabetes who supported and encouraged women with gestational diabetes throughout their pregnancy. A midwife-led diabetes clinic ran alongside the diabetic consultant clinic.

Multidisciplinary working

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

Staff held multidisciplinary meetings to discuss women and improve their care through the safety huddles, however these were not always attended by staff who were required to attend. The huddles were attended by medical obstetrics and gynaecology teams, midwives from all areas of the maternity unit and special care baby unit, obstetric theatre and anaesthetist. Daily cross-site safety huddles took place at 1pm and 10pm. Safety huddles gave clinical staff opportunities to discuss and escalate any operational concerns. However, community midwives did not attend, and this meant there was a lack of oversight of the risks and concerns for whole service.

Managers from most areas met in the morning to discuss capacity and acuity concerns and tried to work together at times of peak activity. In addition, managers regularly liaised with the manager of the neonatal unit for an update on their acuity and capacity.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they had previously required assistance from specialist nurses including cardiac specialist nurses and diabetic specialist nurses when providing holistic care for women

Twice daily handovers were undertaken on the maternity ward and delivery suite. Midwives completed a detailed handover for the women they had been allocated to at the start and end of shifts, using SBAR (Situation Background Assessment Review), and this was used to handover each woman. Women were always referred to by their names and the full history was present, including physical, psychological and emotional wellbeing.

The trust had a team of community midwives who cared for vulnerable women, with complex social needs. Women who booked for care with challenging backgrounds would be referred to the team, consultants and social care where needed. The team would follow up social care referrals. Midwives dealing with women with complex emotional and social backgrounds would attend child protection conferences as part of a multi-professional approach to planning care for babies at risk of neglect harm or abuse.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders were not always aware of the risks, issues and challenges in the service. However, leaders had the skills and abilities to run the service. They were mostly visible and approachable.

Maternity

The service had a clear management structure. It was led by the clinical director, interim director of midwifery, and operations director. This leadership style is referred to as a triumvirate. Members of the triumvirate had clear roles and responsibilities. The interim director or midwifery was line managed by the new chief nursing officer, who met weekly. The leadership team was newly appointed. On the week of our inspection a new interim director of midwifery had started working in the trust.

There were systems in place to monitor services. There were systems that allowed risks to be escalated to the trust board. The trust's new chief nursing officer was the executive lead. A new non-executive director (NED) has been appointed. They worked with other board level safety champions to chair the maternity improvement committee and Clinical Negligence Scheme for Trusts (CNST) review panel.

Staff felt supported by their immediate line managers, despite feeling under intense scrutiny due to recent incidents. This was reflected in the most recent staff survey dated 2020, where 66% of staff responded to 'Immediate manager takes a positive interest in my health & well-being'.

The executive leadership team did not have a full understanding of the day to day pressures and risks faced by the maternity service. There was a lack of oversight by the care group leadership triumvirate of the challenges faced by midwives working in the community setting. For example, there was no community input during cross-site safety huddles. In addition, we did not see equal parts of the maternity service represented in governance meeting minutes we looked at.

The leadership team did not have a visible presence in all work areas. Some staff raised concerns about lack of visibility of the care group triumvirate leadership team of the service. This led to concerns that they did not fully understand the impact of the operational issues on the staff which led to staff being reluctant to raise operational issues or concerns and report incidents. This disconnect between the care group triumvirate leadership team and staff increased the likelihood of a lack of oversight, placing women and babies at risk of significant harm.

Evidence of the disconnect between the executive team and care group triumvirate leadership team and operational staff was evident in the recent staff survey. Although 85% knew who senior manager were, only 27% felt senior managers acted on staff feedback. In addition, 41% felt communication between senior management and staff was effective and 30% felt senior managers involved staff in important decisions.

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, however at the time of inspection it was in draft. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a draft vision and strategy for what it wanted to achieve, which was developed in combination with the maternity voice partnership and other relevant stakeholders. The trust had implemented the 'We Care' programme, to be rolled out to maternity services in September 2021. The model shaped and embedded a patient safety culture at clinical level to deliver sustained improvement throughout the trust.

The service worked collaboratively with neighbouring trusts, clinical commissioning groups, other stakeholders, and service users to establish a local maternity system in response to national recommendations.

Maternity

Culture

Not all staff felt respected or valued and rarely felt supported. However, staff were focused on the needs of the patients receiving care, and the service promoted equality and diversity in daily work.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff told us the needs and experiences of women was paramount and they continued to focus on providing a positive experience for women and babies. However, the staff survey showed only 49% of staff felt they were able to provide the care to women and babies they aspired to give. This was below the organisational average of 62%.

There was a lack of a strong emphasis on the safety and well-being of all staff. Community staff did not feel respected or valued or part of the overall maternity service. Community midwives felt they were not always listened to when they worked at the acute units. Community staff reported feeling unimportant to the service as a whole and that their work was not valued or seen as vital as the acute sites. We spoke with community staff who were upset and tearful.

This was reflected in the staff survey where only 13% of maternity staff felt the 'Organisation definitely takes positive action on health and well-being', and only 35% responded 'In last 3 months, have not come to work when not feeling well enough to perform duties'.

Junior medical staff felt disillusioned and morale was described as "horrific". We were told junior medical staff felt afraid to come to work. They told us that long term sickness for mental health was high, and staff are feeling fatigued. They reported a poor relationship between the maternity and neonatal teams. Often junior doctors felt left when dealing with difficult situations, they were not confident to deal with.

Staff felt they were under intense scrutiny, after recent incidents, but were complimentary about the support they received from their colleagues, despite the challenges that were faced. All staff told us they felt part of a local team and felt they worked well together and supported each other. Staff complemented their local managers and the support they gave them.

Staff were aware there was a Freedom to Speak up Guardian (FTSuG) who supported staff who wished to speak up about a concern or issue. The trust told us no enquiries were received by the FTSuG in relation to maternity services.

Governance

Leaders did not always operation effective governance processes, throughout the whole service or 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.

During the previous inspection, concerns around governance were identified, including the structure and lack of oversight of incidents. Following this, the trust received support from external organisations to make improvements. Governance processes were not always consistent and although concerns were identified, action taken was not always enough to improve the situation.

Governance meetings were held monthly and attended by key staff across maternity which included the clinical governance and patient safety lead, the director of governance, sonographers, pharmacists, and safeguarding leads. There was a clear agenda which included review of the maternity dashboard, safeguarding, the CQC action plan and many other aspects of governance to assess safety across the unit.

However, the community service was not represented at most of the meeting minutes we looked at. This meant the executive team and care group triumvirate leadership team could not be assured they have an overview of the current issues or concerns within the community service. The lack of incident reporting over staffing concerns, and input from this part of the service into daily safety huddles and other essential meetings meant a lack of appropriate process in place to lessen identified concerns.

The new chief nursing officer held weekly meetings with the interim director of midwifery, deputy director of midwifery and heads of midwifery to provide support and guidance, review services and oversee improvements and actions plans. The new chief nurse met monthly with the regional midwifery officer.

The non-executive director chaired the quality and safety committee. The interim director of midwifery and the clinical director attended the board and board sub-committees to present maternity papers and provided a professional voice for midwifery/ obstetricians.

There was a team, whose prime responsibility was to support clinical governance, who reported to the clinical director and the director of midwifery. A director of quality governance was recently appointed at the trust.

Leaders had looked at the serious incident process across the trust. The trust had implemented a multi-disciplinary review approach against the serious incident framework. The director of quality and governance started daily 'touch point' calls to the maternity governance team to provide support and oversight. During these calls, new incidents were reviewed. The risk and governance staff were being mentored on how to review incidents and write reports.

The serious incident and risk team reported to the quality and safety committee monthly and used a standardised governance template. External stakeholders had provided the trust with feedback on their 72-hour reports to support education and learning to the maternity governance teams. This process had a positive effect and gave senior staff the ability to identify and address immediate concerns.

Maternity and neonatal serious incident cases were shared with the improvement director, and external groups. Regular executive-led care group meetings were started to look at action plans to ensure progress. New reporting tools were being developed in compliance with the Perinatal Quality Surveillance Model.

The service complied to all five elements of the Saving Babies Lives Care Bundle. Compliance was reviewed at monthly governance meetings. An action log was completed and adjusted based on the outcomes of audits.

The service was on track to complete all 10 safety actions for the Clinical Negligence Scheme for Trusts. They were being assessed during our inspection and were due to be reported to the Quality Committee and Board in July 2021.

Management of risk, issues and performance

Leaders and teams generally used systems to manage performance. They identified and escalated most relevant risks and issues and identified actions to reduce their impact.

Leaders kept and updated a maternity risk register. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. Current risks included delays in implementing IT systems and waiting time breaches in triage. Information showed the risk manager regularly reviewed and updated the risk register. The risk register was a standing agenda item at the clinical governance meetings that were held every other month.

Maternity

A maternity dashboard was used to benchmark the service against other trusts in the region. Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings. However, we did not see the dashboard shared with staff and the public in clinical areas.

There were processes in place to manage current and future performance, however it was unclear how often these are reviewed and improved. A review of the homebirth service was undertaken. The review found gaps in skills, knowledge and lack of equipment. As a result, all community midwives were scheduled to complete emergency neonatal life support training. As of July 2021, 70% of required staff had completed this training.

Potential risks were not taken into account when planning services. There was a lack of oversight on the workload of day care, triage and community midwives. For example, the service did not audit community telephone calls, including the amount received, the acuity or complexity of the calls and how this impacted on workload. The lack of oversight and monitoring meant there was a failure to understand compliance and performance and an inability to make improvements to the service.

During the COVID-19 pandemic, a decision was made to close the midwifery led units due to lack of staff. Data showed an increase in the number of women requesting a home birth, to numbers above those prior to the pandemic. As a result, the trust developed a new home birthing team called the 'aurora' team who promoted and supported continuity of carer. However, the home birth service was often suspended, as staff were called in to cover the acute sites. On the day of inspection, the aurora team was informed the service was suspended as the night on call midwife was required to cover a shift.

There was a lack of a strong emphasis on the safety and wellbeing of staff. The trust had an emergency maternity escalation policy in place, but it did not include how many hours a midwife could safely work. There was no guidance for midwives working at the acute site to relieve community midwives, make sure they were not impaired by tiredness, and were safe to care for women and babies. Community midwives had seen an increase in being called in via their on-call rota to help cover the unit. Community midwives gave examples when they had worked 20 hours days due to this.

Information received from the trust after the inspection showed the trust had stopped the homebirth service but had reopened the midwifery led units.

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

The service effectively reported and monitored its performance via the maternity dashboard. The maternity dashboard parameters were presented in a format which allowed it to be used to challenge and drive forward changes to practice. The parameters were 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. These included the National Neonatal Audit Programme and MBRRACE-UK. This meant the service was able to benchmark performance against other providers and national outcomes.

Maternity

The service had a systematic programme of clinical and operational audits to monitor quality, and processes to identify where action should be taken. However, we found information collected was not always acted on, and staff told us the outcome of audits were not always shared with them.

Digital systems in the maternity department at the acute site were old. The IT team had a director of IT, a clinically qualified person and chief nursing information officer, who were engaged and working with the digital lead midwife to create a strategy to improve the systems. However, it was felt that the effort required to make maternity digital is generally underestimated.

Engagement

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

Managers worked alongside the local Maternity Voices Partnership to improve care for women. The MVP and Healthwatch were invited to the trusts Maternity Improvement Committee. The trust implemented the Fifteen Steps for Maternity: Quality from the perspective of people who use Maternity services (NHS England 2020) toolkit, in partnership with the MVP. This was to review the woman's experience of maternity services in real time across all aspects of care.

The service collected feedback from women and their families via the friends and family test when women left hospital and were discharged from community care. Friends and family responses were included on the maternity dashboard. Between July 2020 and June 2021, seven of the 12 months the service was above the 90% target for friends and family recommending the service.

The service could give examples of engagement with women. The service had an active social media page which provided public health messages and updates about services and care. Women who posted comments to the page received feedback within 48 hours. During the pandemic, the page had proved to be a vital link to maternity services as it provided reassurance and positive outcomes for women.

The trust had engaged with the maternity voices partnership and women to create the 'home birth' continuity of care teams cross-site. National reports and guidelines cite continuity of care as a key factor in improving outcomes for women. The teams were recruited and implemented, to provide continuity of care for women requesting birth at home. The team planned to provide care for women opting to use the midwifery led unit or the delivery suite. However, due to the concerns found following the inspection the trust had stopped the homebirth service, so they could redeploy homebirth midwives to work in the maternity unit. This was because staffing issues had forced the trust to suspend progress to make the acute setting safe.

Maternity staff engagement in the trust's staff survey was lower than that of other services within the trust. Survey results from 2020 to 2021, did not state how many maternity staff had completed the survey and some data was missing.

Maternity staff had the opportunity to attend staff meetings, held virtually during the pandemic. Meeting minutes were distributed via email.

The service produced a newsletter to inform staff of recent audit and incident outcomes and any new introductions to practice. The newsletter was on display on the ward and within community.

Maternity

The trust engaged with staff from black, Asian, minority and ethnic groups. An event was organised to provide staff with heath information and support with career development.

A Maternity Improvement Committee Member was appointed to engage with external NHS organisations and contributed to the Maternity Improvement Plan at the Evidence Review Committees.

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.

The Trust engaged with external stakeholders to support the upskilling of relevant staff in critical analysis and immediate actions to support 72-hour reports. The trust also sought the help of external stakeholders to undertake a comprehensive review of homebirth incident, including review of policies and guidelines. The service received support from the Maternity Safety Support Programme (MSSP) which was run by NHS England and Improvement.

The trust has implemented a leadership development programme to make sure that improvement plans were implemented, embedded and ensure that clinicians were engaged with the improvements planned for the service.

Specialist mental health midwives were involved in the pilot of a new county-wide maternal mental health service for families who had experienced birth trauma or loss, thanks to a partnership with local clinical psychologists from Kent's mental health trust. The service, called 'Thrive', assesses and supports people experiencing moderate to severe mental health difficulties resulting from experiences during pregnancy or birth. This included birth trauma, loss and repeated unsuccessful IVF and termination.

Areas for improvement

MUSTS

The maternity service

- The service must make sure there is 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. (Regulation 18 (1)).
- The service must ensure there are effective systems to assess, monitor and improve the quality and safety of the services provided. (Regulation 17 (2) (a)).
- The service must embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse. (Regulation 12 (2) (c))
- The service must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. (Regulation 12 (1) (2i)).
- The service must ensure they always use systems and processes to record and store medicines safely and in line with the provider's medicine policy (Regulation 12 (2) (g))
- The service must ensure all staff receive an induction when working in areas they are not familiar with. (Regulation 18 (2) (a))

Maternity

SHOULDS

The maternity service

- The service should consider the environment to ensure women and their families are always treated with respect and dignity.
- The service should consider displaying safety information.
- The service should scrutinize information around ethnicity and use it to inform decision around service development and in monitoring performance.
- The service should put in place a system to provide assurance that the pools were cleaned in line with protocol after every use and were safe for women to use.

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing