Queen Elizabeth The Queen Mother Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

The Queen Elizabeth The Queen Mother Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The maternity service provides services for women within the local area of Thanet and the South Kent coast area. The service has 50 maternity beds across two sites at Queen Elizabeth The Queen Mother Hospital at Margate and William Harvey Hospital in Ashford.

Facilities at Queen Elizabeth The Queen Mother Hospital include one obstetric operating theatre, a consultant led labour ward (with eight labour rooms), an induction bay and a 22-bedded antenatal and postnatal bay. The maternity unit includes a midwifery led unit, which has four rooms, an antenatal triage, antenatal day-care, foetal medicine service and a bereavement room. The service works closely with the level one special care baby unit. However, the special care baby unit was not inspected during this inspection.

There were 2,631 births at Queen Elizabeth The Queen Mother Hospital during the period of January 2019 to December 2019.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced part of the inspection on 22 January and 23 January 2020, along with an announced visit to the hospital on 4 February and 5 February 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Requires improvement** overall.

- New maternity triage guidelines and risk assessments were not yet embedded within the service and we found concerns with the documenting of risk and escalation.
- The service did not have pathways of care for specific conditions which triage midwives could follow. This meant women were at risk of not being seen when potentially they could be scoring high on the 'red, amber, green' (RAG) rating risk assessment.
- The risk rating score was not used when triaging women on telephone consultations. Midwives were relied on to use their professional judgment when determining whether women should be seen within triage, go to the labour ward or to stay at home.
- Staff were not using the Modified Early Obstetric Warning Score (MEOWS) in triage. MEOWS is a nationally recognised, competency-based tool to trigger escalation. Staff were completing observations but not following the MEOWS process.
- Safeguarding training rates for doctors did not meet trust targets. The trust set a target of 85% completion for safeguarding training. Data we reviewed showed medical staff were only 75% compliant in level three safeguarding training.
- There was limited space in labour ward rooms for both resuscitaires and medical and midwifery teams, if an emergency were to occur.
- Documentation was not always clear, up-to-date, or in chronological order because 50% of records were stored digitally and 50% were hand written. Staff told us risk assessments were completed on electronic records and printed off to add to the paper records, but this did not always happen and was not evident on the records we reviewed.
- There were long waits for women within the antenatal day care with one only midwife on duty during each clinic. The trust had just started to audit waiting times to be able to assess the impact and to respond to improve waiting times, but during our inspection we found one woman had waited up to seven hours for a medical review.

Summary of findings

- There was not always sufficient senior doctor cover in the day care clinic. Midwives reviewed and assessed woman and women would only see a doctor if the midwife assessed that there was a concern or risk. Midwives told us that a senior doctor was sometimes available in clinic. However, it was usually a junior doctor with limited experience within obstetrics that would review and discharge.
- From January 2019 to December 2019, the unit did not meet the national target of 95% for venous thromboembolism (VTE) risk assessments. The maternity dashboard showed 92.1% were completed.

However:

- The service provided mandatory training in key skills to all staff. Mandatory training figures which showed that mandatory training figures for midwifery staff had improved and were meeting the trust target of 85%.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
- We spoke with newly qualified midwives, who told us they were well-supported by the midwifery team and senior midwives. Newly qualified midwives received up to 18-months of preceptorship period dependant on their competence and confidence within their role.
- Staff understood and respected the personal, cultural, social and religious needs of women. Women could ask for a female doctor or midwife during procedures or appointments. The hospital had a multi-faith chapel and there were leaflets around the unit.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- People's individual needs and preferences were central to the planning and delivery of tailored services. The maternity unit offered a consultant led and midwifery led birthing unit. The services were flexible, provided choice and ensured continuity of care. The service provided a team of specialist home birth community midwives.
- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care and had access to good information. All women were routinely monitored antenatally as part of the 'saving lives' care bundle.
- The trust had recently introduced scanning all women at 36 weeks of pregnancy to reduce the incidence of birth complications, caesarean sections, breech birth and pre-term babies.
- The service had strengthened its clinical leadership since our previous inspection. The obstetrics team had a new clinical lead and two new site leads. The head of midwifery had been in post since 2018. Staff told us the maternity unit had gone through a number of positive changes since the head of midwifery's appointment and the maternity service was continuing with an improvement plan. Staff told us they felt the head of midwifery was visible and approachable to all staff.
- Leaders had recently improved the governance processes throughout the service with support from partner organisations. However, the new governance processes were not yet fully embedded.
- 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.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with a requirement notice for a breach of regulation/s. Details are at the end of the report.

Summary of findings

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Summary of this inspection

Background to Queen Elizabeth The Queen Mother Hospital

The Queen Elizabeth The Queen Mother Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The hospital is an acute hospital providing a range of emergency and elective services. Maternity services are situated within the original older building.

The hospital is situated within the Thanet area and accepts women from the wider area. There has been an increasing population with high deprivation and a high prevalence of long-term conditions. The area has a high incidence of alcohol related diseases and one in four people living with mental health condition and the highest rates of premature deaths. The service works with a high number of teenage mothers.

The head of midwifery covers all maternity hospital and services within East Kent Hospitals University NHS Foundation Trust and is supported by two deputy heads of midwifery, one of which is situated within the Queen Elizabeth The Queen Mother Hospital alongside a maternity matron.

East Kent Hospitals University NHS Foundation Trust are registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family Planning
- Management of blood supply and blood derived products
- Maternity and Midwifery services
- Surgical Procedures
- Termination of Pregnancy
- Treatment of disease and disorder
- Transport services, triage and medical advice provided remotely

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC inspector, and a specialist advisor with expertise in maternity services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Queen Elizabeth The Queen Mother Hospital

The maternity service provides all aspects of maternity care. The service is registered to provide maternity and midwifery care, family planning, termination of pregnancy and surgical procedures.

The location has both an antenatal triage and day care service with specialist clinics such as diabetes, as well as a full foetal medicine service. A counselling room was available within the antenatal area.

The maternity unit has Kingsgate, an antenatal and postnatal ward which also provides transitional care. Transitional care is in between care for babies who need more nursing care and monitoring than the routine care that babies receive on a maternity ward.

The location also had a consultant-led, eight roomed labour suite, one of which was used for high dependency births and one had a birthing pool. An obstetric theatre and recovery room was also situated within this area. The service had a midwifery led unit with four rooms, two of which had a birthing pool available. The community midwives were located within an office in the midwifery-led unit. A bereavement room was available, which was located away from the postnatal area.

The service worked with the special care baby unit (SCBU) within the hospital. The SCBU had a level one

Summary of this inspection

service. A level one service is a low-level special care baby unit providing tube feeding, oxygen therapy, antibiotics to treat infection and phototherapy for jaundice. The unit accepted babies born above 32 weeks.

The maternity service worked alongside William Harvey Hospital in Ashford, which provided full maternity services as well as two satellite sites providing antenatal appointments and monitoring. The Queen Elizabeth The Queen Mother Hospital maternity services referred babies born before 32 weeks to the William Harvey Hospital, who provided a level three neonatal intensive care unit. A level three service provides complex care to very small or very sick babies.

Community midwifery services are offered across East Kent by six community midwifery teams, who operate out of Children's Centres and GP practices.

We spoke with 30 staff including unit leads, consultants, doctors, senior midwives, specialist midwives, registered midwives, health care assistants, reception staff. We spoke with five women and looked at ten patient feedback comment cards which patients had completed before our inspection. During our inspection, we reviewed 20 sets of patient records.

Activity (January 2019 to December 2019)

- In the reporting period, there were around 6,500 births across East Kent Hospitals University NHS Foundation Trust
- The Queen Elizabeth The Queen Mother Hospital, Margate had 2,631 births
- Home births for the Thanet and South Kent area were 178

Track record on safety (January 2019 to January 2020)

Trust wide for maternity

- Zero never events
- Two maternal deaths
- Seven neonatal deaths within 28 days of birth
- Zero incidents of hospital acquired Methicillin-resistant staphylococcus aureus
- Zero incidents of hospital acquired Methicillin-sensitive staphylococcus aureus
- Zero incidents of hospital acquired Clostridium difficile

Services accredited by a national body:

- UNICEF baby friendly infant feeding stage one.

  Clinical Negligence Scheme for Trusts

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- New maternity triage guidelines and risk assessments were not yet embedded within the service and we found concerns with the documenting of risk and escalation.
- The service did not have pathways of care for specific conditions which triage midwives could follow. This meant women were at risk of not being seen when potentially they could be scoring high on the 'red, amber, green' (RAG) rating risk assessment.
- Staff were not using the Modified Early Obstetric Warning Score (MEOWS) in triage. MEOWS is a nationally recognised, competency-based tool to trigger escalation. Staff were completing observations but not following the MEOWS process.
- Safeguarding training rates for doctors did not meet trust targets. The trust set a target of 85% completion for safeguarding training. Data we reviewed showed medical staff were only 75% compliant in level three safeguarding training.
- There was limited space in labour suite rooms for both resuscitaires and medical and midwifery teams, if an emergency were to occur.
- There was not always sufficient senior doctor cover in the day care clinic. Midwives reviewed and assessed woman and women would only see a doctor if the midwife assessed that there was a concern or risk. Midwives told us that a senior doctor was sometimes available in clinic. However, it was usually a junior doctor with limited experience within obstetrics that would review and discharge.

However:

- The service had enough midwives to care for women and keep them safe. Staff had training in key skills and understood how to protect women from abuse.
- Shift handovers included all necessary key information to keep women and babies safe. Safety huddles were attended by multi-professionals and attendance was mandatory.
- Since our last inspection the service had made improvements to make sure women received one-to-one care during childbirth. The trust also increased its percentage of women receiving continuity of carer.

Summary of this inspection

- Clinical staff complied with the 'Five moments for hand hygiene' as set out by the World Health Organisation and with the trust's hand hygiene policy.
- Staff carried out daily safety checks on specialist equipment. We found equipment was maintained in accordance with the trust's medical devices and systems policy, which covered repairs and planned preventative maintenance.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. All newly qualified midwives felt well supported and were given an 18-month preceptorship period.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care and had access to good information. All women were routinely monitored antenatally as part of the 'saving lives' care bundle.
- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24-hours a day, seven days a week.
- Staff monitored the effectiveness of care and treatment and used their findings to make improvements and achieved good outcomes for women.

However:

- The trust did not review neonatal re-admissions for weight loss or feeding difficulties in babies under 10 days old.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

Summary of this inspection

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.
- Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

Our rating of responsive improved. We rated it as **Good** because:

- The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- People could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

However:

- Women experienced long wait times for medical review within the antenatal triage and day care.
- The service did not have enough obstetric-trained sonographers to complete fetal trimester scans.

Are services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- Leaders had not always identified and escalated relevant risks or identified actions to reduce their impact. Leaders used systems to manage performance, however, these were not always effective in all areas of the service.

Summary of this inspection

- On maternity day care and antenatal triage, standard operating procedures were not embedded. Risk assessing women was not robust and correct care pathways were not always identified quickly, to provide the necessary care and treatment.
- Key patient outcome targets were not showing the targeted reduction in poor outcomes.
- The trust had not achieved compliance with all 10 actions of their safety action plan during the reporting period two remained outstanding.
- Although governance processes had improved since our last inspection with support from partner organisations, the new processes were not yet fully embedded.

However:

- Since our last inspection, leaders had worked to make improvements to its maternity service. The maternity unit had gone through a number of positive changes since the head of midwifery's appointment and the maternity service was continuing to move forward with an improvement plan.
- 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's vision for the planning, design and safe delivery of services was founded in an inclusive multi-professional training and audit program, using the BESTT (birthing excellence: success through teamwork) framework for maternity services.
- The service had developed a task and finish group to look at the current maternity workforce and position structures as part of the new development of the maternity transformation programme.
- The service engaged well with women and the community to monitor plan and manage services.
- The inspection team were welcomed onto the unit during a period where staff and the maternity unit were facing challenging times. Staff were willing to talk with us and wanted to show us the services they provided.
- The maternity service had a clear leadership structure. 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.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	N/A

Requires improvement

Maternity

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are maternity services safe?

Requires improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of women and staff. The trust set a target of 85% completion for mandatory training for all staff and midwives. During our inspection we were provided with up to date mandatory training figures which showed that mandatory training figures for staff had improved and were compliant with the trust target.

Staff completed training by completing online e-learning or face to face sessions and were sent alerts when training was due.

Non-technical skills training was multidisciplinary, and all staff were encouraged to attend, we saw session had been attended by anaesthetists and emergency doctors.

E-learning modules were available for staff on blood glucose monitoring, new-born screening programmes and the growth assessment programme.

Clinical staff completed e-learning and face to face training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. They also completed twice-yearly modules on perinatal mental health and blood transfusion.

Managers monitored mandatory training through training matrix reports and alerted staff when they needed to update their training. We saw staff training records showed completed training, training due and training outstanding.

Data provided after the inspection showed us 96% midwives had completed the neonatal life support training. Community midwives and paramedics completed community simulation training which focused on obstetric emergencies in a home or community setting.

Midwives and qualified nursing staff working within the maternity unit met the trust target for all mandatory training.

Trust data showed, 85% of doctors had completed all aspects of mandatory training and adult and neonatal life support. This met the trust target and complied with the trust's safety action plan.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all medical staff were up-to-date with their safeguarding training, however, staff we spoke with knew how to recognise and report abuse to keep women and children safe.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The trust had two safeguarding teams, one for adults and the other for children and young people. Case discussions, practice reviews and safeguarding audits were monitored through the trust's internal safeguarding committees for adults and children. A designated safeguarding midwife was in place and staff were aware of how to contact the midwife for advice and support.

All women were risk-assessed on admission and midwives we spoke with knew the safeguarding processes, how to make a safeguarding referral and to contact the named safeguarding midwife for further support or advice.

The trust had access to an online child protection information sharing programme to enhance the safeguarding processes and sharing of information. The system checked national database to identify any pregnant woman who may be on a pre-birth child protection plan.

The service did not have a designated midwife for teenage pregnancy. However, all teenage pregnancies and women at risk of sexual exploitation were referred to the safeguarding team.

A safeguarding lead midwife received alerts from the local authority and liaised with midwifery teams to inform them of any vulnerable or at-risk women and families. The lead attended and provided evidence at serious case reviews and safeguarding child protection meetings. Actions and learning from safeguarding meetings were shared with maternity staff.

Staff had a good awareness of supporting women who required further support and had a clear understanding of the processes of referral. We saw women at risk of harm discussed during safety huddles, by the midwifery and medical teams.

Community midwives used a maternity support form to identify any current or previous safeguarding concerns, such as mental health issues, past depression, abusive relationships or social care involvement. This information was identified within the hand-held and electronic pregnancy records and if required, a safeguarding referral was completed.

Women not engaging or not attending antenatal appointments were highlighted to the lead safeguarding midwife and the safeguarding teams. Staff would complete a safeguarding referral and liaise with police if necessary.

Staff had a good awareness of domestic abuse and understood their role to report concerns. We saw leaflets available for women and the unit had signs advising women on where to report domestic abuse. This was in line with NICE QS116 statement 1: people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.

Risk assessments and safeguarding referrals were completed for any potential concerns regarding domestic abuse, child sexual exploitation and female genital mutilation (FGM).

The trust provided a monthly report to the Department of Health on the number of women who have had FGM or who have a family history of FGM. The trust's FGM policy was in date and included a risk assessment and information on how staff could support women affected. The trust safeguarding policy and safeguarding training contained information on FGM.

Safeguarding training also included PREVENT training. PREVENT training provided information and learning on safeguarding people and communities from the threat of terrorism.

There was a high number of young and teenage pregnant women attending the maternity unit. Staff felt confident when working with young women and the trust had a policy in place.

Staff assessed young women between the ages of 13 to 18 years on a case by case basis. They were assessed on their age, family support, age of partner and the accessing maternity care. Community midwives completed the maternity support forms at the young women's first antenatal booking. Information was shared between maternity teams if concerns were raised and a safeguarding referral completed.

Pregnancies in children under the age of 13 would be automatically referred to social services as this was an offence under the Sexual Offences Act 2003. The criteria for referral was set out by the Kent safeguarding children

board. The service automatically completed a safeguarding referral if a young woman was already known to the local authority, were a looked after child, had a concealed pregnancy or an identification of FG).

An abduction policy was in place which outlined the steps staff should take if a baby was abducted from the hospital. It outlined key contact numbers during and out of office hours. The policy required all mothers to wear one identity band and all babies to wear two. This practice was adhered to on the wards we visited.

The unit had an intercom and CCTV to speak with anyone who required access onto the maternity unit. During our inspection, all visitors and staff using the intercom were stopped and asked who they were before being allowed entry and we saw reception staff calling a visitor back because they had not identified who they were. This was in line with The Royal College of Obstetricians and Gynaecologists 2008, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2.2.26. 'Security is an issue of importance for staff, mothers and babies'. A robust system must be in place for their protection, babies born in hospital should be cared for in a secure environment to which access is restricted.

Staff had training on how to recognise and report abuse, and they knew how to apply it. The trust set a target of 85% completion for safeguarding training, all midwives and maternity care assistants had achieved 100% in level two and level three safeguarding. However, the information we received showed medical staff were only 75% compliant in level three safeguarding training.

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.

Personal protective equipment was available in all clinical areas and staff followed the correct use. Side rooms were available for women who had an infection and needed isolation on the antenatal ward, labour or postnatal wards. Staff followed the trust policy on infection control, and we saw long hair was tied back, and staff were "bare below the elbows" at all times.

Staff infection control training compliance was 100% for midwifery and support staff, which was better than the trust target of 85%.

All ward areas were clean and had suitable furnishings which were clean and maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw evidence that staff carried out daily cleaning checks of specialist equipment. Clinical staff complied with the 'Five moments for hand hygiene' as set out by the World Health Organisation (2009) and with the trust's hand hygiene policy. We saw hand gel dispensers were available and in working order across the service. We observed staff, patients and visitors use hand gel. During our inspection we followed the medical team on a ward and observed the medical staff use hand gel before and after patient contact.

Hand hygiene audits showed staff were 100% compliant. There were hand hygiene posters displayed around the unit with dedicated hand hygiene sinks available for staff to use before and after patient care.

We saw posters in the sluice and cleaning rooms, which highlighted colour codes of mops and cloths to suit the cleaning task in line with the NHS national specifications.

Staff told us that higher risk women or healthcare workers were screened for methicillin-resistant staphylococcus aureus (MRSA), and if screened positive they would be referred to infection control for further guidance with a risk assessment completed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

There was secure access to the midwifery unit and staff at the reception desk monitored who had access to the unit to prevent unauthorised access. The maternity unit was situated in the older part of the hospital, which meant there were difficulties in modernising rooms and wards within the unit.

Requires improvement

Maternity

The antenatal suite consisted of antenatal day care, triage and fetal medicine. The suite was located next to the main maternity unit. We found the treatment rooms were well equipped and clean.

Kingsgate ward consisted of three bays and side rooms available for mothers and their babies. The three bays were for antenatal, postnatal care and transitional care. The transitional care bay was mothers and babies who required extra care, observations or antibiotics. Transitional care meant both mothers and babies could stay together whilst accessing care from the special care baby unit. Side rooms were basic but clean. We found the condition of bathrooms and toilets had improved since our previous inspection and all were found to be clean with working showers and toilets.

The labour suite was situated next to the obstetric theatre and recovery. An induction bay was in between Kingsgate ward and the labour suite. An induction of labour is where a labour is started artificially due to a number of reasons where the women has not or cannot go into labour naturally, therefore putting the unborn baby at a potential risk.

The labour suite had eight rooms, one of which consisted of a high dependency room. The room was large and had a baby resuscitaire situated within it. 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.

There was limited space in labour suite rooms for both resuscitaires and medical and midwifery teams if an emergency were to occur. The maternity unit had four resuscitaires within the department. One was situated behind a curtained area in Kingsgate ward next to the transitional care bay, one in the large high dependency room and two within the obstetric recovery room opposite the labour suite rooms.

All staff we spoke with told us if potential risks were identified during early stages of labour the woman would either be moved to the high dependency room or screens would be placed around the open door of the room, and the resuscitaire placed behind the screens. This gave enough room for medical and midwifery teams within the room and mother could see baby at all times.

However, if the risk was immediate and concerns were not identified during early stages of labour the baby would be carried to the resuscitaire by the midwife. This meant the baby was moved away from mother without an identification tag and the mother was unable to see or be with her baby during a potential life threatening and worrying time.

Senior leaders told us they recognised not having the resuscitaires within the rooms was not good practice and there was a lack of privacy and sensitivity for mother and families. The senior teams had completed risk assessments in regard to the positions of resuscitaires and the protocols of what to do in the event they needed to be used. But due to the size of the rooms and where they were positioned, the senior team felt there were no further options available.

The maternity unit had one obstetric theatre for emergency cases. This met national guidelines as the unit had under 3,000 births per year.

Planned caesarean sections took place within general theatres. The general theatre was situated away from the maternity unit, with women travelling there on a hospital bed in open corridors. In the instance where a second emergency case occurred and the obstetric theatre was in use, women were transferred to general theatres. The distance between the maternity unit and theatres took five minutes to move between and a women's dignity and privacy could not be maintained.

The deputy head of midwifery recognised the risks of having an obstetric theatre located away from the unit. The service was in the process of identifying how a second obstetric theatre could be built within the unit.

Staff carried out daily safety checks on specialist equipment. We found the maternity unit followed the Royal College of Obstetricians and Gynaecologists 'Safer Childbirth: Minimum Standards', which states equipment must be maintained in good working order. The equipment was maintained in accordance with the trust's medical devices and systems policy, which covered repairs and planned preventative maintenance. Equipment was kept clean and labelled with green 'I am clean' stickers to provide assurances of dates staff had cleaned it.

The service had enough suitable equipment to help them to safely care for women and babies. We checked 10

pieces of equipment within the maternity unit and all equipment had an asset barcode and log number. This ensured it had been registered onto the trust's medical devices log and had up-to-date servicing and electrical safety testing.

Oxygen cylinders were not kept in a secure locked cupboard. We found oxygen cylinders were placed in a corridor outside of the labour suite. Staff told us this was where all oxygen cylinders were stored. Along from the cylinders we saw several unopened large boxes stacked high on top of each other and the fire door to the corridor was kept open. We found that even after informing staff of the fire door, it continued to be left open.

The delivery suite and the obstetric theatre had the correct emergency equipment. Twice daily checks were completed of the resuscitaires and postpartum haemorrhage trollies. However, we found the oxygen masks and resuscitation equipment had been removed from the packaging ready for use, which did not follow infection control protocol.

At our last inspection, we found the temperature within the maternity unit was very hot for women. There had been difficulty in controlling the temperature due to the design and age of the building. During our recent inspection, the temperature was comfortable and women we spoke with did not complain. The maternity unit was currently in the process of changing the heating system.

Assessing and responding to patient risk

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

The unit had recently introduced a new triage service. The triage service was open 24 hours, seven days a week. The aim was to have a better oversight of risk for women who were experiencing pain or symptoms from 16 weeks of pregnancy and to take the pressure of triage away from the labour ward. However, we found the new maternity triage guidelines and risk assessments were not yet embedded within the service and we found concerns with documenting risk and escalation.

The triage service had in place a RAG (red, amber and green) risk rating score. However, this was not used during the telephone consultations. Midwives were relied on to use their professional judgment when determining whether women should be seen within triage, go to the labour ward or to stay at home. The service did not have pathways of care for specific conditions which triage midwives could follow. This meant women were at risk of not being seen when potentially they could be scoring high on the RAG rating risk assessment.

We looked at six records of women who had attended the triage service following telephone consultation. We found it difficult to review information alongside electronic records and there appeared to be gaps in the assessments.

Staff did not always document assessments and reviews in triage. During the 1 to 3 February, the admissions record showed 98 women had attended triage. On 24 occasions, there were no investigations documented, on 22 occasions there were no outcomes documented and on 18 occasions it was not documented who had assessed the woman.

We found there were long waits for women within antenatal day care with only one midwife on duty during each clinic. The trust had just started to audit waiting times but during our inspection. We found one woman who had waited up to seven hours for a medical review. Staff were advised to complete an electronic incident reporting form if women were not seen within one hour.

Women were not always seen by a doctor in day care clinic following the initial doctor or consultant plan. Midwives reviewed and assessed woman and women only saw a doctor if the midwife assessed that there was a concern or risk. We saw evidence of midwives reviewing CTG for high risk women, women with reduced fetal movements and pre rupture of membranes. It is best practice for CTGs for these groups of women to be reviewed by a senior doctor rather than a midwife or junior doctor. Midwives told us that a senior doctor was sometimes available in clinic. However, it was usually a junior doctor with limited experience within obstetrics that would review and discharge.

Following recommendations after our initial inspection in January 2020, the service put in place an audit to identify how long women were waiting before being seen for a medical review. However, when reviewing the audit, we found the times of when women called the triage service

were not documented on the telephone consultation forms and the telephone calls had not been risk-rated. The unit subsequently put all waiting times on the electronic patient records, reported them in the care group quality and risk report, and introduced a weekly review by a band 7 midwife. A communication tool 'Situation, Background, Assessment and Recommendation' (SBAR) was introduced for all women presenting to triage.

Staff were not using the Modified Early Obstetric Warning Score (MEOWS) in triage. MEOWS is a nationally recognised, competency-based tool to trigger escalation. Staff were completing observations but not following the MEOWS process. We saw three records where, if staff had used a MEOWS chart, this would have identified a risk that required escalation.

Staff on the labour and postnatal wards however were using the MEOWS score. This was clearly documented, along with clear escalation and when an obstetrician was required within the women's notes.

On the labour and postnatal wards, MEOWS and NEWS scores had been completed and reviewed. We saw good identification of infection and diagnosis, to antibiotic times. Patients were prescribed an antimicrobial as clinically indicated and we saw dose and duration of treatment, documented in their clinical records. This was in line with National Institute for Health and Care Excellence, QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Staff did not always follow national sepsis guidelines within the antenatal triage and antenatal day care department. We saw two incidences where the sepsis protocol had been triggered. One woman was sent home with no action taken and no further sepsis documentation completed. The second incidence action was taken but not within the recommended timeframe. Antibiotics had been administered nearly three hours after the initial assessment.

All women at their initial antenatal booking with the community midwife had a standardised risk assessment completed to make sure questions to assess risk were asked by midwives. Social and medical information was taken for all women during booking including information on maternal mental health.

Women who were identified as vulnerable or requiring further support had a maternity support form completed. Risk assessment questions included smoking, health screening, alcohol use and fetal wellbeing. Women continued to be risk assessed during each antenatal contact and postnatally, and assessments were updated when necessary.

There were clear guidelines on observations following an anaesthetic procedure as well as for women post-delivery, possible sepsis and high blood pressure. However, we found the guidelines for post-partum haemorrhage were out of date with the review date being August 2018.

Records demonstrated staff assessed women and babies' health on the postnatal ward every four hours. We observed evidence of regular checks documented in maternity notes. Comprehensive risk assessments were completed for women in labour and postnatally. Neonatal notes included a comprehensive record including a new born examination and a neonatal early warning score (NEWS).

The Situation, Background, Assessment and Recommendation (SBAR) communication tool was used on the labour and postnatal wards for staff handovers and advice calls, as well as transfer and discharge. Midwives used the communication tool to handover from labour ward to postnatal ward verbally. The 'SBAR' was also kept within the body of the patient records. The 'SBAR' was used to ensure assessment, plan and any potential risks were communicated well.

Neonatal feeding charts were used on babies who were known or suspected to have been exposed to drug or alcohol during pregnancy.

There had been previous serious incidents in relation to poor monitoring of fetal heartbeat and uterine contractions when reviewing CTG Following the serious incidents, the trust had put in place weekly training and review of CTG, all medical and midwifery staff were asked to attend.

The trust had adopted a physiological based approach review of CTGs as well as following national guidance to help improve safe outcomes for babies. The rationale the service gave us was that not all women and monitoring fall within the specific categories set nationally. Senior leaders told us looking at the woman's health observations as well as CTG gives a better determination of risk.

Part of the new approach was to use a fetal wellbeing assessment tool. This tool was a sticker which was placed onto the CTG and completed within 30 minutes of the CTG monitoring starting. The aim of the tool was to ask midwives to look at the wider picture of the woman's symptoms. For example, to assess whether there was meconium present, pyrexia, fetal growth concerns or reduced fetal movements as well as monitoring the baseline heartrate.

The trust had introduced a 'fresh eyes and fresh ears' approach to CTG; this followed guidance from the RCOG. Fresh ears used intermittent auscultation (listening to and counting the fetal heart rate (FHR) for short periods), with a second midwife confirming the fetal heart rate pattern every two hours. A second midwife would use 'fresh eyes' to check the CTG interpretation two hourly. We saw evidence that fresh eyes and fresh ears were completed two hourly on women on the labour ward. Midwives told us they liked this approach and felt this gave further reassurance of assessing risk.

Women were assessed for venous thromboembolism, in-line with National Institute of Health and Care Excellence, QS3 statement 1: All patients, on admission, receive an assessment of venous thromboembolism and bleeding risk using the clinical risk assessment criteria described in the national tool. However, From January 2019 to December 2019, the unit did not meet the national target of 95% for venous thromboembolism (VTE) assessment. The maternity dashboard showed assessments were completed for 92.1% of women.

Staff on the labour and postnatal ward had a clear understanding of sepsis and the sepsis six bundle was part of the maternity mandatory training programme. A sepsis policy was in place, a maternity specific tool was used to ensure women were treated in line with recommended National Institute Health and Care Excellence guidelines.

Staff used the World Health Organisation's 'five steps to safer surgery' checklist in maternity surgery. We observed completion of the WHO checklist in women's records and during our inspection, we saw a checklist completed in theatre.

The service had put in place safety huddles. All staff involved in the huddle completed a patient briefing. This highlighted any potential risks or concerns within each of the maternity areas, and women on the labour ward and induction bay were reviewed. Safety huddles were fully embedded into the service. Safety huddles took place twice a day at 1pm and 10.30pm. The 10.30pm huddle was attended by the labour ward coordinator and coordinators from postnatal and antenatal wards. The on-call consultant and midwifery manager would call into the huddle. Attendance of leads was compulsory, and a record of attendance was kept.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and midwifery staff of relevant grades to keep women safe.

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. A health roster administrator was employed to create rosters which took into account preceptorship period for newly qualified staff, long term sick leave, annual leave and training.

Since our previous inspection the trust had an operational leader based at the hospital. The operational leader was available to maternity staff and had oversight of maternity staff for during the day. The operational leader would liaise with the midwifery departments if staffing was low in a particular area. The trust had plans to increase operational leader hours to cover out of hours.

At the time of our previous inspection, the service was not able to provide 1:1 care to all women in labour and the midwife to women ratio was 1:32. Staffing had since

improved, and the unit now provided 1:1 in labour 97.9% of the time. The midwife to woman ratio had improved to 1:28, which was in line with the Safer Childbirth: Minimum standards for the organisation and delivery of care in labour.

A band 7 midwife was shift co-ordinator on the labour ward. The co-ordinator would review staffing, the acuity of patients and capacity levels throughout the shift, and work with doctors and midwives to make sure they had a complete overview on the service during their shift. However, the labour ward co-ordinator was not always supernumerary which was not in accordance with Safer childbirth: minimum standards for the organisation and delivery of care in labour.

The leadership team had recognised the labour ward co-ordinator was not always supernumerary and the band 7 midwives had been asked to complete an electronic risk reporting form if this occurred during their shift.

Staff told us that one midwife from the labour ward allocation had been moved to the maternity unit's new triage service. The rationale behind this was due to the labour ward staff previously took antenatal triage telephone calls. Labour ward staff had raised concerns in regard to the reduction of staff. Staff told us the senior leadership had listened and the labour ward had replaced the midwife. The trust following our inspection had made the band 7 operational leader role 24/7 to provide full oversight and support for midwives.

Although there were adequate staffing levels in line with national guidance, staff told us with sick leave, maternity leave and the complex needs of women and their families within the surrounding areas meant staff felt there were not always enough staff to meet the demands of the service within all areas of the unit, including fetal medicine and day-care.

Vacancy rates

The service had a low vacancy rate.

From January 2019 to December 2019 the trust reported an overall vacancy rate of 5.8% within the maternity department.

Bank and agency staff usage

The unit covered shift using their own staff or through bank staff employed by the trust. Bank staff were used to cover sickness, training and annual leave. The inspection team did not have a breakdown of the bank and agency staff used within the unit.

Sickness rates

From January 2019 to December 2019 the maternity unit's sickness rate was of 4.71% for doctors and midwives and 2.49% sickness rate on the midwifery led unit.

Medical staffing

The service did not always have 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. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Consultant staffing levels were better than the Safer childbirth (2017) recommendation of 40 hours per week for trusts delivering under 6,000 babies per year. The average number of hours a consultant was present on the labour ward was over 80 hours a week. The daily hours of working had also extended for consultants to provide further oversight of women in labour and support to staff. Consultants worked from 8am to 8.30pm.

The trust recognised the lack of full-time middle grade doctors. We were told funding and deanery issues around the recruitment of middle grade doctors was a large factor in the understaffing of middle grades. The levels of middle grade doctors required were dependant on the number of births at the unit per year. However, it did not take into account the more complex medical conditions, social and economic factors of women giving birth within the unit.

Medical staff covered both obstetrics and gynaecology, which put increased pressures on medical staff. The trust was in the process of a recruitment drive for more middle grade doctors to support the number of women with complex medical needs attending the unit.

The maternity service used locum doctors due to the lack of middle grade doctors. We were told by the clinical site lead that due to previous concerns in regard to locum doctors' competences, there was a more robust method

of checking training and competencies for all locum staff working within obstetrics. Locum staff who did not appear to have the confidence or competence within obstetrics were offered further support and were supernumerary on rotas until their competencies were gained.

There was 24-hour anaesthetics cover. If the anaesthetist was busy, then the team had access to the main theatres' anaesthetist to cover any emergencies.

The labour ward co-ordinator gave a full handover to the medical team which included both the on-call night consultant and consultant for that day. The morning ward round started following the end of the morning handover and was attended by the consultant, middle grade doctor and SHO. We saw the midwifery and medical teams working well together. They communicated any potential concerns and discussed the plan of care for that day.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, or up-to-date, because some records were stored digitally while others were paper records. Digital records were easily available to all staff providing care. However, records were stored securely.

Notes were not always contemporaneous, and timelines and care plans were not always easy to access or read. Not all records we reviewed were easy to navigate as the trust used a combination of electronic and paper records. Using two methods of documentation posed a risk during an emergency because staff might not be able to access all the information they needed to inform clinical decision-making.

We reviewed ten records of women attending triage at the unit. We found it was difficult to determine how women had been risk assessed. Not all paper records were fully completed. However, we did see midwives had documented in the paper records when information was contained within electronic records.

We saw poor risk assessments in paper records. We could not see evidence that women in triage had been risk assessed using the RAG rating pro forma, and the time women attended the department and were seen was not documented for any women. Antenatal risk assessments were documented electronically, and staff told us they should have been printed off and placed within the paper records. However, records we reviewed showed us staff did not always follow this process and file a copy within the paper record.

However, we found paper records were well kept following labour and postnatal care. We looked at six notes on the postnatal ward, which showed us the information documented during labour and postnatally was detailed. We saw women had been reviewed by the medical teams and consultant during ward rounds and this was clearly documented. There was clear information to show fetal monitoring had been completed and reviewed by a doctor.

Antenatal bookings were completed electronically and the woman's named midwife and named consultant was clearly noted on each of the hand-held records and booking information. Women were given their own hand-held records to take to every antenatal or hospital appointment. Handheld notes contained a print out of their initial booking, ultra sound scans, health promotion information as well as their fetal growth charts. This was in line with the national saving babies' lives care bundle.

Electronic notes were password protected. The service was able to identify which staff had accessed notes, which ensured procedures conformed to current general data protection regulations.

Records were seen to have stickers or flags alerting to any safeguarding, mental health illness and allergies. Medical and obstetric history was present as well as any on-going health needs. New-born assessment documentation was consistent, with information noted such as baby's feeding and whether skin to skin had taken place.

Mothers were given a Personal Child Health Record (known as the Red book) on discharge. Health professionals used the red books to record information on baby's birth and health, including feeding assessments, new-born checks and new-born hearing screening.

Medicines

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

The trust required all new midwives to complete competencies in medicines management.

Medicines were stored well, guidance for the administration of opioid analgesia and fetal monitoring for women in early labour were followed by staff. Random checks of medication records were completed, and we found patient information and allergies were recorded correctly.

Medicine cupboards and trollies were locked to prevent unauthorised access to medicines. The midwife in charge on the wards and department areas held the keys and only authorised staff had access to these. Medicines that needed to be stored within fridges were stored at the correct temperatures to maintain their function and safety.

Fridges were checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which should be followed if the fridges were not in the correct temperature limits. This protocol was in line with best practice guidelines.

Daily checks of controlled drugs had been completed on the maternity ward and delivery suite. Controlled drugs are medicines that require special management to prevent misuse. Prescribed antimicrobials on patient's medication charts were noted as to when the medication had started, to be reviewed and finished. We saw the dose and duration of treatment documented in their clinical record. This was in line with National Institute for Health and Care Excellence, QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Incidents

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 and families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, the service did not always investigate incidents in a timely way.

All staff we spoke with knew how to report incidents. Incidents were reported on an electronic incident form and staff were informed of incidents in the weekly message, at handover and in the 'risky business' newsletter.

Following previous serious incidents of neonatal and maternal deaths, the service recognised the main risk to the maternity service was the higher risks of incidents and mortality in labour unit. Information on the risk register showed the cause was related to medical cover staffing, with lack of medical obstetric presence, decision making and situational awareness.

Following the investigations into the serious incidents, we found the maternity service implemented learning to improve safety for women and babies. The service had reviewed risks and provided staff with further support and learning with the introduction of weekly CTG training and strengthed locum doctor competencies.

The risk and governance lead for the service reviewed electronic incident forms and liaised with the central risk team to discuss maternity serious incidents, investigations and root cause analysis. Cases were discussed and reviewed with a decision within 24 to 48 hours. The head of midwifery was notified of all maternity risks.

The trust completed deep dive reviews into serious incidents and identified and shared learning from these, such as providing simulation training to staff. These incidents included stillbirths, hypoxia (lack of oxygen to the brain) or controlled cooling. Controlled cooling was a treatment giving to babies with brain injury following a lack of oxygen at birth.

Duty of candour had improved with the head of midwifery and senior maternity leadership had strengthened the way in which they communicated incidents with families following serious incidents. Families were given a point of contact within maternity who they could liaise with as required. Families were involved in reviewing the route cause analysis and were able to raise questions and respond the outcomes of the incident.

The service did not always investigate incidents in a timely way in line with national standards. Evidence provided by the trust showed there were 141 maternity incidents of which 96 low to moderate harm incidents

were under review for more than 60 days at the time of our inspection. The NHS Serious Incident framework published in 2015 requires trusts to investigate and report on moderate harm incidents within 45 days. For serious incidents, a period of 60 days is recommended. A recent report produced by NHS Resolution confirmed that the Women's and Children's care group failed to complete 100% of notifiable incidents within recommended time frames under the maternity incentive scheme.

Never Events

The service had no never events during the reporting period.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January 2019 to December 2019.

All serious incidents were reported to STEIS within 14 days of occurrence.

The trust reported 1,687 incidents, the vast majority were no to low harm, which is indicative of a healthy reporting culture.

Maternity services reported

- 2 maternal deaths
- 7 neonatal deaths within 28 days of birth

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service had a maternity-specific dashboard, which monitored specific safety results. The trust measured metrics for induction rates, planned and emergency caesarean sections, low intervention deliveries, degree of perineal tear and blood loss. Risk management of procedures of third- and fourth-degree tears, shoulder dystocia and post-partum haemorrhage were monitored with a red flagging system. Shoulder dystocia is a rare emergency where a baby's shoulder becomes stuck during the second stage of labour. A red flag would be in place if the incidence of a risk was higher than the trust target.

Are maternity services effective?

Good

Our rating of effective stayed the same. We rated it as **Good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff were committed to provide and promote a normal birth and care was offered in a co-ordinated and flexible way. The unit worked collaboratively with women to personalise their birth choices and a women's individualised needs were reflected when planning how care was delivered. For example, women were given the choice to have a consultant led birth in the labour ward, a midwifery led birth in the midwifery led unit or a home birth. This was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22: Antenatal Care.

Maternity leads monitored policies and ensured clinical updates were mostly reviewed. Audits were reviewed yearly and most policies three yearly. We saw most policies were updated in line with the National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Some staff told us that finding policies on the intranet could be difficult as policies were being transferred to a

new policy centre on the intranet. All policies we reviewed were current and a review date was set, other than the post-partum haemorrhage policy which had an overdue review date of August 2018.

During our last inspection the trust had launched their maternity transformation programme, birthing excellence success through teamwork (BESTT). The aim of BESTT was to reduce avoidable term admissions to neonatal intensive care unit (NICU), reduction in term stillbirth and to reduce obstetric anal sphincter injuries. The maternity service was continuing to follow the BESTT transformation programme when we recently inspected, and all staff were aware of and following the BESTT transformation programme.

Women were risk-assessed for gestational diabetes and offered glucose tolerance testing in line with NICE guidance NG3 (2015) on Diabetes in pregnancy. 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.

Staff measured and recorded fundal height (the height of the uterus) to assess fetal growth during pregnancy from 24 weeks and there was a clear escalation policy and pathway for abnormal findings. This was in line with Mother and Babies: Reducing Risk through Audits (MBRRACE-UK) and NICE CG62 (2019) on Antenatal care for uncomplicated pregnancies. The fetal medicine team worked alongside obstetric sonographers and fetal medicine consultant obstetricians to develop a care pathway for any high-risk group.

Midwives and obstetricians emphasised the importance of fetal movements to women at each antenatal contact as a method of fetal surveillance. We saw that midwives documented the details of the conversation in the antenatal records. As highlighted by MBRRACE-UK (Mother and Babies: Reducing Risk through Audits) and in line with the current Royal College of Obstetricians and Gynaecologists guideline (Green-top Guideline No.57) and document the detail of this conversation in patient records.

The service used a gestation-related optimal weight assessment. The aim of assessment was to identify fetal growth restriction within the antenatal period. We saw women's maternity records, which showed us fundal height assessments at antenatal appointments were being completed. The trust had introduced a universal 36-week growth scan for all women in line with best practice. The scan checked the health of the placenta and the fetal growth.

Women with a multiple pregnancy had care planned and provided in accordance NICE quality standards for management of twin and triplet pregnancies in the antenatal period. Women were cared for as a high risk and would follow the high-risk care pathway. Women had a dedicated consultant lead and midwife.

Women who needed a caesarean section, whether planned or not, received care in line with NICE Quality Standard 32 (2013) on Caesarean section. Women were offered a choice of a vaginal delivery following previous caesarean sections. Pregnant women who requested a caesarean section with no clinical cause had a documented discussion during their antenatal appointment to discuss the overall risks and benefits of a caesarean section compared with a vaginal birth.

Women and their partners were supported and encouraged to have skin-to-skin contact with their babies following birth. Skin-to-skin contact with babies soon after birth supported parental bonding and improved temperature regulation of new-born infants. The service had posters around the unit promoting the advantages of skin to skin contact with babies. The trust reported 72% of women were offered skin-to-skin contact following birth. However, this did not meet the national average of 82% provided by the NHS Maternity Statistics, England 2018 -19. Staff told us delayed cord clamping of babies was promoted, this is in line with NICE CG190 (2018) on Intrapartum care for healthy women and babies. However, we did not see this evidenced within the women's records we reviewed. Delayed cord clamping meant more blood reached the baby immediately after birth and may help to prevent anaemia.

The relevant NICE quality standard (37) was adhered to in respect of post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All women we spoke with had been given feeding advice and support. Most midwives within all areas of the unit were able to undertake the New-born Infant Physical Examination training.

The maternity service had recently signed up for the national bereavement care pathway. The bereavement service was developing guidance to make the bereavement experience better and focused on women and their families. A bereavement database was set-up for midwives to access information to support women and their families.

Staff protected the rights of women subject to the Mental Health Act 1983 and followed the code of practice. The trust had a policy for perinatal mental health. There were guidelines for midwives completing antenatal booking, around past or current mental illness and family history as well as providing ongoing care for women in the labour and postnatal period who have or are experiencing mental ill health.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Women's emotional wellbeing and the needs of the woman were discussed at each handover meeting between all staff, and during safety huddles with the medical and multidisciplinary teams.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women helped themselves to breakfast and staff would serve breakfast to women who were unable to move around easily. The midwifery-led birthing centre had a small kitchen for making refreshments and partners could make themselves a snack if required.

Women received support to breastfeed after birth and this continued onto the post-natal ward. However, between January 2019 and December 2019 the trust breast feeding initiation rate was 67.3%, which was worse than the trust target of above 74%. However, the unit's maternity dashboard showed some women changed from artificial feeding to breastfeeding within 48 hours of birth with support from staff.

The trust had started the level one UNICEF baby friendly breastfeeding initiative. The initiative was designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. Level one of the accreditation required the trust to put in place facilities to achieve the baby friendly standards. This included written policies and guidelines to support standards, an education programme to allow staff to implement the standards according to their role, processes for implementing standards and auditing and evaluating standards.

An infant feeding co-ordinator was in place and worked and oversaw the breast feeding initiative and gave feeding advice to women and staff. The unit had feeding support staff to offer extra advice, support and guidance to women experiencing difficulties with breastfeeding. The staff member also supported mothers on how to feed their babies using aids for a 'hands-off' approach. Women told us they felt well supported.

Additionally, babies were weighed at birth, and day five, with babies weighing under 2.5 kilograms weighed on day three.

We saw breastfeeding and artificial feeding advice available on the trust website, within the wards and displayed on notice boards. We saw posters giving guidance on responsive and effective feeding. There was access to breast pumps and a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available. Staff knew which women required support with feeding their baby as staff discussed the baby feeding regime at handover. This included the women's feeding preference, their progress with feeding their baby and babies who had artificial feeding.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. A pain tool was used within the maternity department to identify a woman's choice and timeliness on receiving pain relief.

Staff prescribed, administered and recorded pain relief accurately. Women had access to a range of pain relief

methods in accordance with NICE CG190: Intrapartum care for healthy women and babies. This included pharmacological pain relief such as Entonox (gas and air), pethidine (a morphine-based injection) and epidurals during labour. Epidurals were available 24 hours a day, seven days a week.

Women who had an intrapartum death (death of a baby in the womb) had a plan to ensure adequate pain relief for labour. Staff discussed women's level of pain and subsequent management plans during handover. This ensured all staff knew which women required review of their needs in relation to pain. .

Non-pharmacological pain relief were available such as birthing pools and birthing balls. Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain). Beds could also be adjusted to be at different heights and angles.

Patient outcomes

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

The service reviewed the effectiveness of care and treatment through local and national clinical audits. The service participated in MBRACE-UK (Mother and Babies: Reducing Risk through Audits) and ATAIN (Avoiding Term Admissions into Neonatal Units). The trust also submitted data on antenatal and new-born screening programmes.

The maternity transformation programme had been introduced to improve key areas set out within the National Maternity Review report 2016. We found the unit fell below the trust target in all three key areas within the transformation programme.

From January 2019 to December 2019 the Queen Elizabeth The Queen Mother Hospital was meeting the national standard for reducing term stillbirths. The stillbirth rate at the trust during this period was 2.49%, which was better than the national standard of 2.6% and the national average of 2.8%.

During the reporting period the percentage of term babies admitted to the NICU unit was 2.9%, which is better than the national average of 3.6%. However, the trust's performance was worse than the national standard of 3.5% for reducing the incidents of obstetric anal sphincter injuries, at 3.7%.

The trust had employed two fetal wellbeing midwives in January 2020, one at the Queen Elizabeth The Queen Mother Hospital and one at William Harvey Hospital. The fetal wellbeing midwives were employed full time to oversee the implementation of the saving babies lives care bundle. The aim of the initiative was to provide information to reduce still births and reduce pre-term birth through reducing smoking in pregnancy, risk assessment and monitoring of fetal growth restriction, raising awareness of reduced fetal movement and effective fetal monitoring during labour.

The fetal wellbeing midwives had only recently come in to post. We were told the aim of the new role was to look at how the saving babies lives bundle was currently monitored through audits and guidance. The aim was for the midwives to update the current guidelines and practices. To incorporate new guidance and to make sure all staff were up-to-date with current guidance.

From January 2019 to December 2019 the unit had a higher number of elective, emergency and total caesarean rates compared to the national average.

National Neonatal Audit Programme

In the 2018 National Neonatal Audit the two measures relevant to the maternity unit are showed below:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

The maternity unit was within the expected target range of 83.6%. However, this was worse than the national audit's recommended standard of 85%.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

The 2018 data showed that this information was not submitted for the unit due to the low numbers of babies given magnesium sulphate.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

PReCePT programme is an evidence-based programme designed to help reduce cerebral palsy in babies through the increased antenatal administration of magnesium sulphate to mothers during preterm labour. Preterm labour is a woman having regular contractions before the 37th week of pregnancy.

Competent staff

The service made sure staff were competent for their roles. However, not all locum doctors employed were experienced in obstetric care. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We spoke with newly qualified midwives, who told us they were well supported by the midwifery team and senior midwives. Newly qualified midwives received up to 18 months of preceptorship period dependant on their competence and confidence within their role.

Each newly qualified midwife had competencies to complete. Some competencies required newly qualified midwifes to be observed a number of times before being signed off, such as cannulation and suturing.

All new staff attended the administration of medicine course and medicine competencies were to be completed following the training.

The service had a clear training matrix, which was in line with NHS England care bundle 'Saving babies lives' 2019, which included learning on smoking cessation, risk assessments, surveillance on fetal growth restriction, raising awareness on reduced fetal movements, effective fetal monitoring during labour and a mental health care pathway.

The matrix outlined learning for all maternity staff. Midwives attended three full day skills training sessions. These were skills and update in maternity, which included human factors update, risk, obstetric and anaesthetic emergencies. There was also a fetal monitoring study day which included cardiotocography (CTG) training. Staff had to review three CTGs and complete an assessment at the end of the training session. A CTG records the fetal heartbeat and the uterine contractions during pregnancy.

Following a serious incident in regard to a locum doctor's competencies, the trust had since put in place competencies and a log of locum training. We saw documentation which showed all locums were given a full trust induction on starting with the trust. Locum doctors had to complete competencies before working on-call. Information was given to locums such as emergency call numbers, accessing guidelines and policies as well as the mandatory training required.

All locums received clear guidelines for cardiotocography monitoring. A consultant or senior registrar was responsible for signing locum doctors off as competent to work in the unit. We were told if staff raised concerns in regard to the competency of a locum doctor, then they would be observed and if necessary be supernumerary on rotas until they were signed-off as competent.

The maternity service was keen to develop staff interests and skills, and since our last inspection we found there to be more specialist midwifery roles. These included leads in diabetes, bereavement, fetal wellbeing, perinatal mental health, better births, an infant feeding co-ordinator and a new risk and governance role.

The unit's aim was to increase the number of band 7 midwives so that junior midwives could feel more supported when making difficult decisions and dealing with the complex cases that come into the unit.

Midwives rotated around the different areas of the maternity unit to ensure they were continuously using and keeping up to date with midwifery skills, except some permanent midwives who worked within the midwifery led unit. However, if there were no women on the midwifery led unit then staff would work either in the labour or postnatal wards.

Midwifery support workers had the opportunity to attend training to increase their knowledge and skills. There were maternity support workers who had specialist training in breastfeeding support, taking bloods, and doing routine observations of patients.

Midwives told us they felt very well supported by the deputy head of midwifery and senior team to develop their skills and interests. Most of the specialist midwives within the department told us their role developed from having an interest in the specialist subject such as bereavement and perinatal health to specialised midwifery roles.

Requires improvement

Maternity

The maternity service had recently introduced a more supportive clinical supervision. TRiM, a trauma risk management approach offered staff an opportunity to reflect with a TRiM trained colleague or manager if they had experienced a difficult or traumatic situation.

Senior staff and maternity leads attended team meetings and provided information and feedback. Managers identified poor staff performance promptly and supported staff to improve. We saw documentation of monitoring poor staff performance, including regular meetings and an action plan with learning, monitoring and support.

Managers appraised staff work performance. Appraisals were benchmarked against the visions and values of the trust. Objectives, aims and training needs were discussed with staff during their appraisal. Data provided by the trust showed from January 2019 to January 2020, 85% of all staff within maternity services had received an appraisal.

Multidisciplinary working

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

We observed obstetric staff and midwives working well together. There were systems to manage and share information.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care through the safety huddles. The huddles were attended by the medical obstetrics and gynaecology teams, midwives from all areas of the maternity unit and special care baby unit, obstetric theatre and anaesthetist. Safety huddles gave clinical staff opportunities to escalate and discuss any operational concerns. Staff felt the evening huddle gave a full oversight of any potential risk.

Staff from different areas attended the maternity risk and governance meetings and these were held at either trust site and were an opportunity for medical and maternity teams from Queen Elizabeth The Queen Mother Hospital to get together with staff from William Harvey Hospital.

We observed good practice in line with Safer Childbirth, which states there must be 24-hour availability in obstetric units of senior paediatric colleagues, who have advanced skills for immediate advice and urgent attendance and would attend within 10 minutes. The maternity unit liaised closely with staff in the special care baby unit regarding any baby that required transfer of care.

There was mostly good communication and working relationships between midwives in the unit and community midwives. All midwives worked well with the safeguarding team and information sharing through maternity support forms. Midwives liaised with perinatal mental health midwife safeguarding, social care, GPs and health visitors. Staff involved in complex cases would attend safeguarding case conferences as part of the multi-disciplinary process.

Seven-day services

Key services were available seven days a week to support timely care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24-hours a day, seven days a week.

Midwifes, consultants and anaesthetists were available on site. Consultants were available from 8am to 8.30pm, Monday to Sunday. During all other times, 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 would dial into the 10.30pm safety huddle each evening. An on-call system was in place and we reviewed the medical rotas and found sufficient cover was in place. This was in-line with The Association of Anaesthetists of Great Britain and Ireland, Obstetric Anaesthetic Guidance: An anaesthetist must be immediately available for emergency work on the delivery suite 24 hours seven days a week, and National Health Service, Seven Days a Week, Priority Clinical Standards.

There were on-site pharmacy and pathology services that were available at all times of day and night. Maternity services offered a 24-hour triage service. This service could be accessed at any stage of pregnancy.

Fetal anomaly screening was available Monday to Friday from 8am to 8pm, and urgent ultrasounds examinations were available at all times if needed.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit.

Information was displayed on boards throughout the unit for women and visitors to read. For example, smoking cessation, infant feeding, dietary advice and diabetes in pregnancy. The maternity page on the trust website had a video about the woman's journey through pregnancy, labour and beyond.

Staff supported women to live healthier lives. At the initial antenatal visit, staff risk-assessed women for immunisations and past medical history. Women were offered the flu and pertussis (whooping cough) vaccination. Health promotion including healthy eating and smoking cessation was discussed and documented in antenatal records.

All women were routinely monitored antenatally as part of the 'saving lives' care bundle. Women were monitored at 12, 20 and 36 weeks of pregnancy. Carbon monoxide monitoring was offered to all women whether they were past or current smokers. Between January 2019 to December 2019 carbon monoxide tested at booking was 98.7% which was better than the trust target of 95%.

Women were given information on local antenatal classes by midwives as well as classes including health promotion initiatives and lifestyle choices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

When women could not give consent, staff made decisions in their best interest, considering the woman's wishes, culture and traditions. Staff knew about consent and decision-making requirements of legislation and guidance. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental health assessments and specific wellbeing questions were included in the booking and pregnancy assessments at 28 weeks between patient and midwife. Women at risk were easily identified on the computer system and risk sections were visible. A maternity support form was completed, and information was shared to professionals such as the health visitor. We saw evidence that these sections had been completed for women with concerns.

Staff we spoke with were confident in supporting women with additional needs, such as learning difficulties. Midwifery staff could give examples of where antenatal booking would start with the community midwives, but they would work together to make sure a woman with learning disabilities had a birth plan in place and that they had visited the unit and felt well supported.

Staff understood Gillick Competence and Fraser Guidelines and supported children and young women who wished to make decisions about their treatment. The unit had a high number of teenage and young mothers attending. Staff were confident to assess the young woman and to make sure they had the support they needed. Staff made sure they gave young women choices to make informed decisions about their care.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Nursing and midwifery staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The training was combined with the trust induction and adult safeguarding training.

The maternity service included perinatal mental health awareness training within the mandatory yearly maternity update day.

All medical staff completed dementia awareness training, which included consent, mental capacity Act training and deprivation of liberty safeguards.

Are maternity services caring?

Requires improvement

Maternity

Good

Our rating of caring stayed the same. We rated it as **Good.**

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff took the time to interact with women and their families in a respectful and considerate way.

Staff understood and always respected the privacy and dignity needs of women in their care. During a ward round, the co-ordinator ensured women were appropriately covered to respect their dignity and curtains were pulled around bed spaces before intimate examinations were performed. This is in line with the National Institute of Health and Care Excellence (NICE) QS15 statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

We observed kind and supportive advice given to a woman who was anxious and wanted breastfeeding support.

Staff introduced themselves and made women and their families aware of their role and responsibilities. We observed all members of the team introduce themselves to women and their partner or families, when either on the ward round or when assessing their health. This was in line with NICE QS15 statement 3: patients are introduced to all healthcare professionals involved in their care and are made aware of the roles and responsibilities of the members of the healthcare team.

Staff responded in a compassionate, timely and appropriate way when women experienced physical pain, discomfort or emotional distress. We saw staff explaining to a woman the process of epidural pain relief. This is in line with NICE QS15 statement 2: patients experience interactions with staff who have demonstrated competency in relevant communication skills.

Midwives and doctors displayed an understanding and a non-judgemental attitude when talking about women who had mental ill health or a learning disability. Staff recognised when extra time and support may need to be given to a woman who had an additional need. During handover and at safety huddles, staff discussed the additional help and support some women needed during their stay and after discharge, due to having mental health needs.

We found midwives and doctors understood and respected the personal, cultural, social and religious needs of women. Women could ask for a female doctor or midwife during procedures or appointments. The hospital had a multi-faith chapel and there were leaflets around the unit.

Friends and Family test performance

The maternity unit had a good response from the friends and family score. From January 2019 to December 2019 it scored 97% in its friends and family score. The friends and family scores are assessed to ensure women and their families have a positive experience of care.

The unit received responses from women and their families as to whether they would recommend the service following their care:

The midwifery led unit received 30 responses, and were 100% recommended;

The labour ward received 69 responses, and were 98.55% recommend; and

The postnatal ward (Kingsgate) received 75 responses and were 96% recommend.

Comments we saw from women and their families included, “every midwife cared and were very thorough”. “Everyone was lovely and made you feel comfortable”, “the staff always kept me as up to date as possible and I felt certain they knew what they were doing”.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it to minimise their distress. The service provided an appointment based listening service called ‘birth afterthought’ for parents who wanted to review their maternity notes and birthing experience with a senior

midwife. All women were given a leaflet about the service on discharge from hospital. Community midwives had details of the service to give to women and their families also.

The unit had a wide source of bereavement resources and we saw women, partners and their families were well supported by the bereavement team. The services provided were in line with the Stillbirth and Neonatal Death Society (SANDS) guidelines on pregnancy and baby loss.

The trust had two specialist bereavement midwives, with one based at the Queen Elizabeth The Queen Mother Hospital. The bereavement midwife worked clinically and covered the role two days per week. The bereavement midwife was proactive and keen to develop the service further. The service was currently looking at recruiting bereavement champions to support the service and setting up a rainbow clinic for women and families who fall pregnant following the loss of a baby.

Staff contacted the bereavement specialist midwife by mobile as and when needed. Support included telephone, calls, clinic appointments as well as help with funeral arrangements and referrals to counselling.

The bereavement midwife worked closely with the gynaecology team to ensure women received sensitive care following a pregnancy loss at any gestation. Pathways of care had been designed to support women and partners with contact, and support was offered up to two years following the birth of their baby. We observed examples where parents were supported to take their baby home for a few hours, had time to hold, bathe and dress their baby. The service had recently been given permission and resourced funds to build a garden alongside the bereavement room. The bereavement room was slightly away from the delivery suite and was well thought out. It provided a homely environment that was non-clinical. There was a cold cot available, with packs providing plaster casts of hand and footprints, and photographs. There was also a specific pack given to women who had had a miscarriage with guidance for support and keepsakes.

The service provided a listening service for women who had experienced a traumatic labour and birth to review their birth records, talk about their birthing experience and feelings in relation their birth. The service was provided weekly and we were told by staff that it was well attended by women and their families.

Staff undertook e-learning training on breaking bad news and demonstrated empathy when having difficult conversations. The antenatal clinic had a counselling room where midwives broke bad news to expectant mothers.

Understanding and involvement of patients and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff involved patients and those close to them in decisions about their care and treatment. We observed consultants and midwives in the antenatal clinic discuss birthing options and explain the risks and benefits of each to expectant mothers. This was in line with NICE QS15 statement 5: patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Across the maternity services women, their partners, friends and relatives had access to a variety of information to help inform their choices. For example, there was breastfeeding, and artificial feeding information displayed around the unit. There was also a maternity page on the trust website which showed a video of the woman's journey from pregnancy, through labour and delivery.

Are maternity services responsive?

Good

Our rating of responsive improved. We rated it as **Good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

People's individual needs and preferences were central to the planning and delivery of tailored services. The maternity unit offered a consultant led and midwifery led birthing unit. The services were flexible, provided choice and ensured continuity of care. The service provided a team of specialist home birth community midwives.

We found the maternity department to be easy to find for women and their families. The unit was next to a main entrance and a car park was situated directly outside. The trust provided satellite clinics for antenatal care across east Kent, which meant women could access antenatal care locally.

Partners or relatives could stay overnight to support the woman. Midwives told us women preferred partners to stay for support. All women had hand held maternity notes which they took to each appointment. We observed information in the maternity notes which flagged any potential concerns.

Since our previous inspection and in response to concerns raised in the early identification of fetal risk, and to reduce the admissions onto labour ward, the unit had introduced a maternity triage service. The triage service offered 24-hour care and took concerns from women who were 16 weeks pregnant or more and had pregnancy related concerns. For example, reduced fetal movements, vaginal spotting and abdominal pain. The woman would go through a triage process over the telephone and either sent directly to labour ward, invited into triage or given advice and reassurance over the telephone. Information on the antenatal unit was found on the trust website along with emergency contact numbers for any pregnancy related concerns outside of opening hours.

The unit was in the process of providing 'Better Births', an imitative to improve maternity services and continuity of care. The service was looking to create smaller teams where women were looked after by two or three midwives throughout their care to provide continuity. Community midwives were already working towards providing continuity and women would remain with the same community midwife or buddy throughout their care. The National Institute of Health and Care Excellence (NICE) Antenatal Care: QS2: continuity of care, states "pregnant women are cared for by a named midwife throughout their pregnancy".

Interpreters and 24-hour translation services were available for women who did not speak English. The trust had a service in place which provided British sign language.

The service did not have a specific team or midwife working with vulnerable women or women with complex needs. Women living in vulnerable circumstances, such as those who were drug dependent, living with learning disabilities or other complex needs were referred to the safeguarding team, local authority and health visitors.

The trust employed a perinatal mental health midwife who was a point of contact for staff to discuss women who may need additional support for their perinatal mental health needs. The service had perinatal mental health guidelines in place and staff knew where to access them. However, the service did not offer a consultant-led perinatal mental health service in line with the NICE Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (2020). The guidance advises a specialist multidisciplinary perinatal service should be provided in each locality. The aim of the service would be to provide direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity. These services may be provided by separate specialist perinatal teams.

The unit worked with the maternity voices' partnership group. The group heard from mothers and families who had previously used the service. The group included the deputy head of midwifery and women from minority groups, fathers, teenagers and bereaved parents. Maternity leads attended the group to listen to the views of mothers and women using the service. The deputy head of midwifery told us this partnership worked well and was insightful when planning care and treatment for women.

The maternity voices partnership worked with the trust to provide longer clinic times for women to talk about their birthing plan and concerns. Hypnobirthing was piloted at the Queen Elizabeth The Queen Mother Hospital. Hypnobirthing is a method of pain management that is used during labour and birth. It involves using visualisation, relaxation and deep breathing techniques during labour. Staff told us that the natural birthing method worked well with women.

The service did not have enough sonographers trained in obstetric scanning to meet the demand of the service and women were experiencing waits to be scanned. We were told that there had been concerns raised that not all staff scanning women were obstetric-trained due to the demand for obstetric scans. However, the trust had secured funding to provide training for four midwives to be trained in trimester scanning.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The unit provided support and arrangements for women whose first language was not English. The maternity unit was aware of the local demographic and knew there was a high population of non-speaking English women using the service. Interpreters and 24-hour translation services were available for women who did not speak English. The trust had a service in place which provided British sign language. Staff knew how to access translation services.

The trust provided satellite clinics for antenatal care across east Kent, which meant women could access antenatal care locally.

Women with learning or physical disabilities or mental health needs were referred by their community midwife to the maternity unit to discuss the women's needs and provide a plan of care. This included the use of appropriate rooms, whether self-transfer was possible, and bathroom facilities. Not all facilities within the labour ward were wheelchair-accessible. Women's hand-held records had information on the women's physical and social needs and referrals for appropriate support.

The midwifery led unit was for women who were planning on birthing their babies as naturally as possible and for women who did not want a home birth. The unit had four rooms, all with ensuite facilities and two with birthing pools. The MLU was bright, clean with artwork and posters on the walls throughout. It was located closely to the delivery suite which ensured easier access if required. The community midwives had an office within the MLU and there were facilities for women and partners to help themselves to food and drink.

Women had to fit certain criteria to use the midwifery led unit. A woman had to be full term (37-42 weeks pregnant), wished to give birth without an epidural, expecting a single baby and had not had any previous complications in pregnancy or labour. All the midwifery led unit midwives were experienced in normal birth, hypnobirthing, water birth, massage and active birth. Pain relief available included hydrotherapy, Entonox, pethidine, paracetamol, and dihydrocodeine.

Since our last inspection, the counselling room had been refurbished. It was clean and bright with pictures and a comfortable sofa. There were leaflets and literature available for women and families. The room felt more relaxed and calming to have difficult conversations in.

Safer childbirth standard 2.2.20 states "Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given". Midwifery unit manager told us that they would try to accommodate a women's birth choices and a meeting would be arranged to discuss a woman's birth plan if they did not meet the criteria for the midwifery led unit. If it was felt that the woman's birth choices were outside of current safety guidelines, then the risks and information would be given to give the woman an informed choice. Information was documented clearly in patient records.

Staff used the Whooley screening tool to identify women at risk of depression. This was in line with NICE antenatal and postnatal mental health guidelines. Women who answered yes to both questions on the tool were referred for further support. Women who had tokophobia (an intense anxiety or fear of pregnancy and childbirth) were assessed and referred for a consultant review. Women could also be referred to the mother and infant mental health service. This was a service offered by community health services.

The trust employed a consultant midwife for public health, the role was not to follow individual women throughout their pregnancy but to look at the health inequalities within the local area.

The unit had a frenotomy clinic which was managed by the infant feeding team. The service was for babies under

12 weeks for tongue tie. Tongue tie is where a thin piece of skin called the frenulum attaches the tongue to the base of the mouth, which stops the tongue moving freely which affects feeding.

The unit had a transitional care bay on Kingsgate ward. This provided babies who needed extra care or observations following birth to stay with mother whilst they received extra care or medications such as antibiotics.

Access and flow

People could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The maternity unit dashboard showed us that more than 90% of women saw a midwife for their antenatal booking appointment before 13 weeks. This met the trust target and was in line with NICE QS22 statement 1. To improve the service offered to women the maternity unit offered an online booking process. This minimised delays in appointment allocation.

The service did not monitor or audit the waiting times for women in triage or day care. We were told by women using the service, and staff, that waiting times could be long and meant at times women waiting long periods of time when having a medical review. Staff told us that women could be waiting a number of hours to be seen by medical staff. This meant high risk and unwell women were delayed in receiving a medical review. Waiting times for both triage and day care were not monitored or audited prior to our inspection. We raised concerns with the trust in regard to the waiting times not being monitored and they introduced monitoring of arrival, wait and seen times.

The unit had a triage service which was available to all women of 16 weeks pregnancy. Women had access to the triage service, 24-hours a day, seven days a week.

The service had a specialised fetal medicine clinic. Timely screening tests took place and the service had a consultant obstetrician with a special interest in fetal medicine, as well as a specialist fetal medicine midwife. Women pregnant with fetal abnormalities were seen regularly within the antenatal unit. Women could access the fetal medicine midwife easily and were well supported. However, we found clinic appointments had long delays and there were not always enough appointments available to meet the demand of women pregnant with fetal abnormalities.

The maternity dashboard showed the total number of unit diverts (where women in labour were directed to other hospitals because the unit was full) from January 2019 to December 2019 was 10, and the trust aimed for the unit to have zero diverts. The data did not indicate the number of women who were diverted to other trusts. The unit had been closed once within the period.

From January 2019 to December 2019, 84.7% of women diagnosed with type 1 diabetes were referred to obstetric clinic within four weeks of booking appointment. This was worse than the national average of above 90%.

There were 289 readmissions of women back into the hospital from January 2019 to January 2020 and 339 babies aged 28 days and under.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

The service reviewed complaints and treated concerns and complaints seriously, investigated them, learned lessons and improvements were made as a result. People who used services and staff were involved in the review.

There were leaflets available in the maternity department which informed women how to make a complaint about the service. This included speaking to the patient advice and liaison service. Patients could seek further information on how to raise a complaint on the trust's website. A notice board was seen on the unit which identified how to make a complaint and whom to contact.

We reviewed four recent complaints from January 2019 to December 2019. All four complaints met the trusts agreed timeframe for responding to complaints. The deputy head of midwifery reviewed all complaints. All relevant staff involved in the complaint were spoken with as part

of the investigation process. Lessons learned and actions taken were discussed with complainants, brought to staff in team meetings and added to the risky business newsletter. Staff we spoke with said complaints were taken seriously.

Are maternity services well-led?

Requires improvement

Our rating of this well-led stayed the same. We rated it as **Requires improvement**.

For this core service inspection our assessment of well led is an assessment of the leadership, governance and management within the Womens and Childrens care group. However, we did interview the trust's medical director and chief nurse during this inspection.

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.

We found senior managers at all levels in the service had the right skills and abilities to run the maternity service. Leaders within the maternity unit were knowledgeable, experienced and well respected by all staff we spoke to during our inspection.

The care group incorporated maternity, gynaecology and neonatology. The midwifery senior leaders and matrons had a shared purpose to deliver and motivate staff. The leadership structure was formed of a clinical director, a head of midwifery and an operations director.

The maternity service had a clear leadership structure in place and staff were clear about their roles and accountabilities. Midwives and maternity support workers reported to the ward sisters who then reported to the matrons. The matrons reported to the deputy heads of midwifery who reported to the head of midwifery.

The obstetrics team had a clinical lead and a two new site leads. The head of midwifery had been in post since 2018 and was the driving force behind change within the maternity service. The clinical groups report to the chief operating officer and the chief nurse. However, the chief nurse did not have responsibility for the delivery of the maternity transformation programme; this was the responsibility of the head of midwifery.

Staff told us the maternity unit had gone through a number of positive changes since the head of midwifery's appointment and the maternity service was continuing to move forward with an improvement plan. The head of midwifery was visible and approachable to all staff.

The unit's deputy head of midwifery was highly respected by all staff we spoke with. Staff felt valued and listened to and told us the deputy head of midwifery was visible and would offer support whenever asked. The deputy head of midwifery was responsible for the staffing, safety and governance at the hospital.

The unit had a matron, who at the time of the inspection was on long term sick leave. We were told by the deputy head of midwifery that they were in the process of appointing a band 7 staff member to act-up in to the matron post.

The deputy head of midwifery had oversight of services including the community midwifery services. This included updating staff on changes to practice, compliance, incident reviews and auditing service to meet national and trust targets.

We found staff were confident in sharing ideas with senior leaders in regard to making changes to the service and were encouraged to do so. Staff would push forward ideas for improvements to the department, alongside their own personal development. Midwives in specialist roles told us that they had been encouraged to develop their areas of interests further and were given the time to develop.

The service had direct access to the trust board every month through the care group governance board meeting. Several meetings fed into this meeting including the risk governance and quality. This allowed information to be fed up to the board and back to frontline staff.

We saw that the senior team wanted to improve services and the introduction of the triage service was to alleviate

pressures for staff in the labour ward, and to provide a more robust oversight of women at risk. However, we found during our inspection that this was not yet embedded.

Senior managers attended a number of meetings including weekly labour ward meetings, monthly matrons' meetings, perinatal meetings, mortality and morbidity, governance and risk and quarterly risky business meetings which were held across sites. Staff told us they were notified of changes and felt up to date with what was happening within the maternity service.

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.

Staff told us there was a clear vision within the maternity service. Staff were provided with regular maternity updates on changes to the service and were asked for their opinion and views.

During our last inspection the trust launched their maternity transformation programme 'Birthing Excellence: success through teamwork (BESTT). BESTT was designed on the Safer Childbirth 2016 report, standards for the organisation and delivery of maternity care. The service was continuing to work towards the transformation programme and to review serious incidents and lessons learnt.

A task and finish group was set up by the care group which focused on workforce and job plans as part of the maternity transformation program had been introduced to improve key areas. The purpose of this is to provide senior presence in obstetrics and paediatrics to ensure appropriate cover of women's and children's services. The care group leads engaged with the consultant body to lead on developing the maternity transformation strategy and the approach to increased consultant cover.

The group report to the Maternity Support Program learning and review committee which has an externally appointed chair

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.

Staff told us there had been a huge improvement in working relationships between the midwifery and medical teams, since the head of midwifery had come into post, and the change within the governance structure. We saw respect for each other's roles and consultants were said to be responsive to concerns raised. Multidisciplinary working was evident across the unit with midwives having clear links with gynaecology and the special care baby unit.

At our last inspection, not all midwifery staff felt confident to approach consultants and there were concerns raised in regard to consultant attitudes towards more junior staff. Midwifery staff told us at our recent inspection relationships between midwifery and medical staff had improved. Midwifery staff told us consultants were always available and most consultants listened and respected fellow staff.

The inspection team were welcomed onto the unit during a period of time where staff and the maternity unit were facing challenging times. Staff were willing to talk with us and wanted to show us the services they provided.

Staff were encouraged to report any incident of bullying or racism to senior managers and through the trusts speak-up guardian. Staff we spoke with told us they felt confident to be able to raise any bullying concerns and knew who their speak-up guardian was. We saw a clear process for escalating any concerns over performance issues and staff felt able to challenge each other.

Staff were offered the opportunity to talk with senior staff following the serious incidents. Staff told us they felt well supported by senior staff as well as supporting each other.

Information was shared across teams, showing learning from incidents and promoting incident reporting. There was a good reporting culture and staff were clear on how to complete an electronic reporting form.

Requires improvement

Maternity

Governance

Leaders had recently improved the governance processes throughout the service with support from partner organisations. However, the new governance processes were not yet fully embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The change from divisions to clinical groups in 2018 was significant for the Women's and Children's care group. They were in a multi-speciality division previously, along with cancer, and they had a limited voice within the previous divisional structure.

We found effective structures, systems and processes to support delivery of the maternity service. The governance structure was demanding on the triumvirate. They developed the strategy for the service and made significant changes despite these demands on their time. However, key patient outcomes are not showing a targeted reduction.

The development team are due to review the BESTT programme to make sure it reflects the current priorities of the maternity service.

Since our previous inspection there had been involvement by a number of outside professional bodies following the number of serious incidents and neonatal deaths within the trust. Part of this process was to develop a clear oversight of the governance processes, incidents and risks.

The systematic program for clinical and internal audit monitoring of quality, operational and financial processes, had been embedded into the care group. Doctors and midwives engaged with the program and collected data via internal digital systems.

A new risk and governance lead in post who had clear oversight of the current actions as well as the governance processes, incidents, risks and learning within the service. All meetings were cross-site so that all staff could be involved and learning shared.

Teams attended a weekly risk meeting to discuss clinical risks, a monthly clinical governance meeting, a weekly perinatal mortality and morbidity meeting, audit meetings and a care group governance meeting.

We reviewed several meeting minutes which showed actions were taken and information was disseminated through into the maternity departments through information boards, a risky business newsletter, message of the day and meeting minutes. Information was reported to the executive board.

Managing risks, issues and performance

Leaders used systems to manage performance, however, these were not always effective in all areas of the service. Leaders did not always identify and escalate relevant risks and identify actions to reduce their impact. However, the service had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had previously not always identified and escalated relevant risks or identified actions to reduce their impact. The service put in measures to mitigate risks with the new triage service as well as introducing more training and oversight of fetal monitoring. However, senior maternity leaders failed to recognise that guidelines and the assessment of risk were not embedded within antenatal triage and day care service. The service did not audit waiting times for women attending triage or how long they waited for a medical review. Record audits had taken place but staff completing the audit had not identified the lack of risk assessment taking place.

The maternity service's risk register identified their top risk as the higher rate of incidents and mortality and recognised there was a lack of medical obstetric awareness involved within the incidents. However, there continued to be a lack of a senior obstetric doctor reviewing women within triage and day care.

Following our inspection, the trust provided assurances there was now a greater oversight of antenatal services by the leadership team and the service was now recording

when women accessed the triage service. Staff were encouraged to complete an electronic incident reporting form for women waiting longer than one hour for medical review.

Risk was monitored through local and trust wide meetings. Other than risks we identified in triage and on the day unit, we found risks on the maternity service's risk register were consistent to the concerns shared by maternity staff and there were current plans to address these risks. The maternity risk register was reviewed monthly to identify any issues within performance. Information from the review meetings were fed through into the trust risk and governance monthly meetings.

At the time of our inspection, the trust had not achieved compliance with two out of 10 national maternity safety actions to support the delivery of safer maternity care. The focus for the trust was compliance with the following 10 national maternity safety actions:

1. Use the National Perinatal Mortality Review.

2. Submit to the Maternity Services Data Set.

3. Demonstrate the service has a transitional care service to support the Avoiding Term Admissions into the Neonatal unit's program.

4. Demonstrate effective systems of medical workforce planning.

5. Demonstrate effective systems of midwifery workforce planning.

6. Demonstrate compliance with all four elements of the Saving Lives Care Bundle.

7. Demonstrate effective patient feedback mechanism for maternity services.

8. Evidence that 90% of maternity unit staff have attended in house multi professional maternity emergencies training.

9. Demonstrate trust safety champions obstetricians and midwife are meeting bimonthly with board level champions to escalate locally identified issues.

10. Report 100% of qualifying incidents under NHS Resolutions Early Notification scheme.

The Women's and Children's care group had failed to achieve compliance with all 10 actions. The trust confirmed that they were compliant with the eight out of the ten safety actions. Safety action 5: the planned review of actual labour suite supernumerary status was not supported through the current audit tool, to be able to comply with this action. The trust had requested funding to look to develop an acuity tool that will capture and report all workforce data in one reporting repository. The trust's submission also failed to assure NHS Resolution of its compliance with safety action 10. As to whether the trust reported 100% of qualifying incidents under NHS Resolutions Early Notification scheme.

Managing information

The service collected reliable data and analysed it most of the time. Staff could find most data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, data or notifications was not always submitted to external organisations as required.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training and development opportunities for staff, infection control, parenting advice and educational material for new parents.

Guidelines were stored electronically on the intranet, however, staff told us they were not always easy to find.

We saw arrangements to ensure that data or notifications were submitted to external bodies as required. However, data was not always reported in a timely way. We found there were arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. This included an alert system to inform staff where patients may require additional mental health or emotional wellbeing support.

The maternity departments page on the trust website was informative. The page gave women and their partners guidance throughout the pregnancy and birth journey with links to videos and clips. A social media page was also in place and this offered women and partners to

comment and interact with midwives. Breastfeeding advice and current guidance were seen, as well as information on signs and symptom of perinatal mental health.

Women's confidentiality was protected, and we found all computers were password protected and staff locked the computers before walking away.

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.

Clinical engagement had been a priority and the care group acknowledged the need to continue to strengthen this to support the quality improvements and changes in ways of working. Senior midwives told us they were keen to listen to women to develop and improve maternity services.

The maternity voices' partnership, before their forum with maternity staff, attended local drop in sessions at local children centres and were involved with the local antenatal groups in the local area to gain views about the maternity facilities from local women in the community. Social media had also been a way for the service to gain information and feedback from users. Women were invited to comment on local guidelines and patient information leaflets. The chair of the maternity voice partnership attended the divisional board meetings and local forums and took part in the recruitment for the service.

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.

Continuous learning, improvement and innovation was encouraged and developed in order to improve care for women across the trust. The service offered simulation training using real incidents.

The maternity service had a consultant who had a 50% clinical and 50% educational role and supported on the delivery of training within the Birthing Excellence: success through teamwork transformation (BESTT) programme.

The service, using research, had adopted a physiological approach to fetal monitoring to provide a better oversight of fetal and maternal risk during labour. Staff told us they welcomed the new approach and it gave them support and reassurance when making clinical decisions.

The maternity service had created the faculty of multi professional learning in maternity. The service provided highly advanced simulators for staff training and was the only maternity unit in England to have undertaken quality assurance in clinician's essential life support skills.

The service introduced TRiM (Trauma Risk Management) which was a focused peer support system designed to help people who had experienced a traumatic, or potentially traumatic, event. Staff had completed training to become TRiM practitioners.

The trust had recently developed a pregnancy app to give pregnancy and health promotion advice. The app was designed to be used by women at the start of their antenatal booking. Women and professionals could access pregnancy notes, past medical history allergies and birth plan. Community midwives could access the app to see if any alerts had been entered to contact the woman. The app could also highlight if antenatal appointments or scans had been missed.

Senior midwives told us there was a lack of support for fathers. The service was in the development stages of planning a 'whose shoes' for fathers, to offer them a voice and support.

The bereavement midwife had been voted for an excellence in bereavement care award. There were plans in progress to offer rainbow clinics for pregnant women who had previously experienced a loss of baby. The clinics offered counselling and mental health services as well as joining the continuity of care pathway.

Outstanding practice and areas for improvement

Outstanding practice

- The trust created a faculty of multi professional learning in maternity, and invested in state of the art simulation equipment, which allowed all staff exposure to simulated 'real life' emergency situations.

Areas for improvement

Action the provider MUST take to improve

- The trust MUST ensure women are risk assessed at initial telephone contact in antenatal triage and on admission to the triage unit. Regulation 12(2)(a)
- The trust MUST ensure all women are assessed in antenatal triage using the modified early obstetric warning score. Regulation 12(2)(a)
- The trust MUST ensure all women are seen by a medical clinician within the specified timeframe set by national guidelines dependant on risk. Regulation 12(1)
- The service MUST provide a senior obstetric doctor to have full oversight of antenatal triage and day care. Regulation 12(2)(b)
- The trust MUST ensure that it mitigates the risks associated with using a combination of paper and digital patient care records. Regulation 12(2)(b)

Action the provider SHOULD take to improve

- The trust SHOULD ensure it continues to monitor the risks related to the siting of resuscitaires and that it implements measures to mitigate identified risks
- The trust SHOULD consider the impact on women's privacy and dignity when reviewing the siting of resusictaires

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