East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Our findings

Overall summary of services at William Harvey Hospital

Requires Improvement 

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

We visited the maternity units at the William Harvey Hospital on the 21 July 2021. We visited the community midwifery services at Kent and Canterbury Hospital on the 22 July 2021.

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

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

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

See the maternity section for what we found.

How we carried out the inspection

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

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

We spoke with over 25 staff including executive staff, service leads, midwives, medical staff and maternity support workers, consultants, registrars, junior doctors and student midwives.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, which focused on three domains of our key lines of enquiry (KLOEs) safe, effective and well led. As a result of this inspection ratings for this service remain unchanged. The rating stayed as requires improvement.

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

Maternity

Requires Improvement  

Our rating of this service stayed the same.

- The service provided mandatory training in key skills to all staff but not everyone completed it.
- The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- Medical staff had not completed their safeguarding training.
- The premises and facilities were not designed to keep women safe during labour because there was limited space.
- Staff in triage, day care and community did not always have enough time, knowledge and skills to consistently assess women or babies. Appointments were hurried this was because the unit was short staffed, and managers used junior staff to backfill the gaps.
- Women having their first baby did not all receive a home visit. Staff completed telephone consultations which meant there may be missed opportunities to monitor mother and babies wellbeing and protect them from neglect or abuse.
- The leadership team had the skills and experience to run the care group and they supported staff to develop their skills and take on more senior roles. However, they did not always understand and manage the priorities and issues the service faced. Not all of them were visible and approachable around the hospital for patients and staff.
- Not all staff felt respected, supported or valued; but they focused on the needs of patients receiving care. Not all staff felt that the service promoted a culture of equality and diversity in daily work or provided opportunities for career development. Leaders recognised the culture needed to improve so that patients, their families and staff could raise concerns without fear.
- Leaders did not always operate effective governance processes, throughout the service or with partner organisations. Not all staff were clear about their roles and accountabilities, although they had regular opportunities to meet, discuss and learn from the performance of the service. Because of this the trust was in the process of strengthening governance across all divisions.
- The care group did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events but did not always have the capacity or staffing to implement those plans. Not all staff had the opportunity to contribute to decision-making to help avoid financial pressures compromising the quality of care.
- The trust collected reliable data and analysed it information systems were secure, but they were not integrated. Which meant staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

However;

- Midwifery staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwives training was up to date they knew how to recognise, and report abuse and they knew how to apply it.
- Managers had recognised risks about the premises design and completed regular risk assessments. Staff maintained equipment to keep people safe, and trained staff to use it. Staff managed clinical waste well.

Maternity

- The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, lack of staff posed a risk to the safe assessment and monitoring of all women and babies.
- Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service had made improvements to how it managed patient safety incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers implemented actions from patient safety alerts and monitored outcomes. Although, not all staff understood why incident reporting was important.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.
- Staff provided evidence-based care and treatment in line with national guidelines. Managers monitored the effectiveness of the service and made sure staff were competent. 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. Key services were available seven days a week.
- Leaders focused on making improvements to the service, they used monitoring systems to review services and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- 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 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.
- Leaders and staff actively engaged with women, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- 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.

Is the service 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 but not everyone completed it.

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

Maternity

Medical staff received and kept up to date with their mandatory training most of the time. The trust had developed a multidisciplinary learning environment that focused on all aspects of obstetric and midwifery skills to deliver safe, emergency care.

The mandatory training was comprehensive and met the needs of women and staff. Training was updated because of COVID-19 social distancing constraints and now included an electronic version of practical obstetric multi-professional training (PROMPT).

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

Staff received yearly updates in monitoring the fetal heart. The fetal monitoring study day included a competency assessment rolled out in July 2020. Accurate fetal monitoring is vital to assess fetal wellbeing. Records confirmed that 95.7% of all health care professionals working in maternity services were compliant.

The practice development lead midwife monitored mandatory training and alerted midwifery staff when they needed to update their training. During the COVID-19 pandemic, the trust postponed face to face sessions which has affected training compliance rates. In response, the trust had created a training recovery plan detailing clear actions to improve compliance. At the time of our inspection, the trust had begun to restart face to face sessions.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwives training was up to date. They knew how to recognise, and report abuse and they knew how to apply it.

Midwifery staff received training specific for their role on how to recognise and report abuse and neglect. Midwives were trained at level three for safeguarding in line with the 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (Royal College of Nursing, 2019). Records showed 91% of midwives were compliant with their safeguarding training.

Medical staff received training specific for their role on how to recognise and report abuse.

However, records showed 68% of medical staff were complaint in level three safeguarding training and only 50% were compliant in level two. This was much worse than the trust target of 95%. This meant medical staff may not recognise and report abuse.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Patient records flagged women who had safeguarding issues so that all staff could easily identify these families and make sure they were receiving the appropriate help and support. Midwives attended case conferences with social care professionals and families so that communication between health care professionals protected women and children at risk of abuse. However, some midwives reported they had high caseloads of women referred to social care which meant they many case conferences to attend which affected their workload.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed safeguarding risk assessments during the midwives 'booking in' appointment. As part of the assessment, midwives routinely asked questions on mental health, domestic violence and female genital mutilation where applicable. This was in-line with national guidance.

Managers identified gaps in safeguarding with third party organisations. For example, those working on the border did not always provide safe handover of pregnant non-English speaking refugees or migrant women in their care. This was fed back to the leadership team so action could be taken to liaise with external services.

Staff were able to provide examples of safeguarding referrals they had made. Maternity services followed the threshold criteria set out by the Kent Safeguarding Children multi-agency partnership. Midwives referred pregnant girls under the age of 13 to social care as an offence under the Sexual Offences Act 2003. Also, staff automatically referred girls under 16 known to the local authority, such as looked after children, concealed pregnancies and any identified cases of FGM in this age group. Staff provided evidence of serious case reviews and the learning outcomes from these. This confirmed the service was engaging with external stakeholders and using learning to improve safeguarding for mothers and babies.

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

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Safeguarding training included modules on recognising deteriorating mental health and supporting women who had complex needs for example learning disabilities or severe mental health disorders.

Staff followed the infant abduction procedure. Staff told us they labelled babies at birth and access to all areas was password protected to keep babies safe.

Staff did not always visit new mothers at home for their first visit following birth. This meant there were missed opportunities to see the home environment in terms of highlighting safeguarding issues. We raised our concerns following the inspection and managers told us they would re-introduce first home visits in line with updated national guidance.

Cleanliness, infection control and hygiene

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

Ward areas were clean and but did not always have suitable furnishings that could be cleaned and maintained. The trust only scored 71.8% in cleaning audits which fell short of the stakeholder local service level agreements requirements of 95%. The most common reasons for failing audits was damaged equipment, furnishings or issues with the estates.

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

Staff cleaned equipment after patient contact and labelled equipment to show when last cleaned. This helped identify equipment that was clean and ready for use. Equipment was visibly clean and had access to disinfectant detergent wipes to clean after each use.

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

Staff followed infection control principles including the use of personal protective equipment. All staff, including community staff called in to cover the unit, were 'fit tested' so they could use the correct face masks. Personal protective equipment, such as gloves, aprons and masks were available in all areas. All staff we spoke to had received both doses of the COVID-19 vaccine.

All patients attending the hospital had their temperature taken. Staff screened all pregnant women for COVID-19. Records showed that during the last 12 months, 260 pregnant women had tested positive for COVID-19 across the whole maternity service. Records showed the maternity unit reported all hospital acquired infections and acted on themes following investigation.

Staff knew how to manage patients who were suspected/confirmed COVID-19 positive. COVID-19 positive women were admitted to safe areas for care and visitors were not allowed. To maintain social distancing guidelines. The trust reduced the number of visitors and staggered visiting times in line with social distancing rules.

Staff testing for COVID-19 was embedded, staff completed lateral flow tests twice weekly, this was important to protect patients. Staff who had a positive lateral flow test, self-isolated until they had a confirmed COVID-19 polymerase chain reaction (PCR) test.

Environment and equipment

The premises and facilities had not been designed to keep women safe during labour because there was limited space. Managers had recognised this and completed regular risk assessments. Staff maintained equipment to keep people safe, and trained staff to use it. Staff managed clinical waste well.

The design of the environment did not follow national guidance. The hospital was built in 1977 and some areas were no longer fit for purpose. The delivery suite, maternity day care and triage area were small and cramped, and the main treatment area was not private.

The service did not have suitable facilities to meet the needs of women's families. The delivery suite rooms did not have bathrooms and there was no room to store neonatal resuscitation equipment. A neonatal resuscitaire is a device which combines a warming therapy platform along with the components needed for clinical emergency and resuscitation. The neonatal resuscitaire's were located at points within the delivery suite. One was in a small clinical room which contained other emergency equipment. The service had risk assessed and monitored this issue which was on the trust's risk register. Managers updated the service's resuscitaire risk assessment during regular monthly meetings.

A review of the privacy and dignity of women on labour ward at the hospital was undertaken in October 2020. The review recommended follow on actions to improve the privacy and dignity of women, including ordering of new screens, and improving the decoration to create a more 'homely' environment.

Staff carried out daily safety checks of specialist equipment. This meant equipment in good working order and ready for immediate use. Records for June 2021 showed that staff completed daily checks were on all emergency equipment.

Staff had enough suitable equipment to help them to safely care for women and babies. Resuscitation trolleys throughout the unit were labelled and contained the correct equipment. Community midwives carried a home birth bag which had recently been reviewed and standardised. This meant community midwives could open the bags and locate what they needed without delay. There was a separate neonatal resuscitation bag, which community midwives collected prior to attending a woman at home.

Staff disposed of clinical waste safely. Staff segregated clinical waste in line with best practice. Bins were colour coded and sharps bins labelled with dates and times of when installed and removed, these were accessible within all clinical areas.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, lack of staff meant there were times when midwives were very busy which posed a risk to the safe assessment and monitoring of all women and babies.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed booking assessments when women presented for care. The mother's medical, social, and emotional history were recorded and prepopulated on to a digital assessment tool. This helped to place women on the appropriate care pathway.

Staff used a standard operating procedure to assess and review women from black, Asian and minority ethnic groups (BAME) in response to the Royal College of Midwives and the Royal College of Obstetricians report, 'Coronavirus (COVID-19) infection in Pregnancy (2020)' which identified that these women were at five times greater risk of having poor outcomes. The trust monitored ethnicity via the booking assessment and at each point of the care continuum.

Women whose first language was not English had access to interpreting services and the care group offered women with darker skin vitamin D in line with national guidance. Other risk factors like obesity, diabetes, social deprivation and maternal age were factored into the risk assessments and women assessed as high risk were referred for obstetric assessments.

Staff followed a standard operating procedure for virtual assessments of pregnant women and babies during the COVID-19 pandemic to reduce the spread of the virus. However, the operating procedure was generic and not aligned to maternity care guidelines.

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

Maternity

Maternity triage was open 24 hours a day seven days a week for women who were experiencing pain or symptoms from 16 weeks of pregnancy. Women who had concerns about their pregnancy before birth or postnatally, could contact the maternity triage. The service had pathways of care for specific conditions which triage midwives followed. Triage and day care staff completed telephone assessments of women calling the unit with concerns using a colour coded risk assessment form.

Staff escalated concerns using a standardised SBAR (situation, background, assessment and risk) tool which they attached to the patient records and transferred with women to either theatre or the ward. However, we saw that SBAR handovers were brief and not thoroughly aligned to the SBAR handover tool. After the inspection we requested evidence that the trust monitored the use of MEOWS, partograms and SBAR tools. However, the trust did not provide this, which meant there was a lack of oversight on the effectiveness of this tool.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the MEOWS (Maternal Early Obstetric Warning Score) assessment tool to identify women at risk of deterioration and escalated them appropriately throughout the unit. Staff worked well together to highlight deteriorating patients.

Staff caring for women in labour completed assessments using, partograms, cardiotocograph (CTG) readings. A partogram is a graphical presentation of a woman's progress of labour, whilst a CTG measures the baby’s heartbeat and monitors the contractions in the womb. findings were documented in the care record.

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

Based on national recommendation the trust had implemented a fresh eyes and fresh ear approach to interpreting CTG’s. However, incident reviews confirmed these checks were not fully embedded.

Staff knew about and dealt with any specific risk issues. Staff completed venous thromboembolism (VTE) assessments prior to elective surgery or during the postnatal recovery phase on the ward to make sure women did not develop a blood clot. However, staff told us that midwives working on the delivery suite were not routinely completing VTE assessments prior to discharge to the ward. This meant there may be delays in women obtaining the correct treatment. Staff had escalated this to a ward manager but had not completed an incident form.

Staff followed standard operating procedures for women who chose to have a caesarean section. Women attended a pre assessment clinic where they had a review of their health, routine blood tests, MRSA swabs and routine medicines. Doctors explained the procedure and gained consent prior to surgery.

Staff completed a theatre checklist for women transferred there during labour for invasive procedures which included a caesarean section. The checklist followed World Health Organisation’s (WHO) ‘Five Steps to Safer Surgery Checklist’. In addition, two staff were responsible for counting swabs and making sure all instruments used accounted for.

Managers made sure staff used the obstetric anal sphincter injury (OASI) care bundle which is a set of interventions to reduce the risk of perineal trauma. The tool included checks that staff had gained consent, checked maternal allergy status and had the procedure explained.

Maternity

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

Staff on the wards completed postnatal checks prior to discharging women into the community. Assessments were completed on mother's physical, emotional and social wellbeing. Feeding advice was given and mothers were given the contact details of the unit and advised to call if they felt unwell. Discharge notifications were sent to the community midwives, health visitors and general practitioners.

However, some staff did not have the time or skill to appropriately risk assess women or babies in triage, day care or the community. For example, on the day of our inspection, day care staff had a half hour slot to complete a booking which was not enough time to safely holistically assess women's health and emotional wellbeing and plan their pregnancy care. Staff told us that this happened when the unit was short staffed or there was a high volume of admissions

Unqualified staff were answering the telephone to women who needed advice and support. This was because this aspect of care had not been factored into the staffing acuity tool. Unqualified staff did not have the necessary skills to safely assess concerns raised during telephone consultations.

Staff did not consistently monitor mothers who smoked in line with the saving babies lives care bundle. We found notes were missing carbon monoxide (CO2) assessments. CO2 screening is not only about establishing smoking status but making sure pregnant women and their families are safe from poisonous gases. CO2 monitoring had stopped during the COVID-19 pandemic. This had recently been reintroduced for pregnant women 36 weeks and over at the booking process. The trust had not submitted any data on C02 monitoring between June 2020 and July 2021 on the maternity dashboard and trust records showed low uptake of C02 monitoring by women.

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

Staff told us that the trust did not provide gold standard equipment of bilirubinometers to accurately assess jaundice in newborn babies. We raised concerns with the trust who agreed to review current practices.

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm or provide the right care and treatment all the time. Managers reviewed and adjusted staffing levels and skill mix, but these did not always meet local demand.

The service did not have enough midwifery staff to keep women and babies safe. Community midwives reported it was common practice for them to backfill shifts at the acute hospital site. Records showed that in June 2021, the service used community midwives to backfill hospital shifts 59 times. In one week, managers on the unit called community midwives to help backfill shifts on 24 occasions. Community midwives gave us examples of times when they worked 20-hour days because they were 'called in' to cover the acute unit. Staff told us they were understaffed which led to stress and anxiety. Staff across the unit were exhausted and told us they rarely had time for breaks despite working 12-hour shifts.

Managers reviewed the number of staff needed for each shift but did not accurately calculate staffing levels per national guidance. Managers did not have reliable workload data to make accurate calculations for the midwifery staffing establishment because the service did not monitor all activity undertaken by midwives, for example the number of telephone calls taken by the triage midwives.

Managers adjusted staffing levels daily according to the needs of women in labour. Managers used a nationally recognised live acuity tool to review staffing within the unit. The tool risk rated staffing levels through the day and highlighted periods of unsafe staffing.

The number of midwives and maternity support workers rarely matched the planned numbers. If staffing levels were unsafe, staff followed the maternity escalation policy and diverted labouring women to other hospitals. Records showed that from April 2021, the unit had diverted care to other hospitals six times. This meant women might be transferred to other hospitals during labour, which could create anxiety.

Managers could not limit their use of bank staff because the service was understaffed. However, many shifts went unfilled and community staff were used to backfill shifts. Managers had created financial incentives to encourage staff to work extra hours, but most staff were too exhausted to work more than their contracted hours. Records confirmed managers requested 6187 hours of bank shifts from January to June 2021, this equates to six whole time equivalent staff and reflects the shortfall in staffing across the unit.

Managers limited their use of agency staff but requested staff familiar with the maternity unit Records showed that 1404 hours were filled by agency staff at the William Harvey hospitals maternity unit between January 2021 and June 2021. However, there were times when women were cared for by unfamiliar staff who may not have had regular exposure to the units policy's and equipment.

Managers rolled out a recruitment programme and offered 15 posts to newly qualified midwives who were due to start in September 2021. A further four experienced band 6 midwives were also due to start at the same time.

Midwifery staffing across at the hospital was not adequate to protect women and babies. After the inspection, we raised concerns about staffing levels with the trust. As a result, the trust decided to suspend their homebirth service, so they could redeploy homebirth midwives to work in the maternity unit and keep mothers and babies safe whilst completing a review of community midwifery working hours.

Managers could not guarantee that women would receive one to one care during labour, in line with NICE (2017) Intrapartum care for healthy women and babies clinical guideline. One to one care increases the likelihood of a normal birth and better outcomes for women. Staff told us there were numerous times when they cared for two women at the same time.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough obstetric consultants to keep women and babies safe. The national standard for a unit with 2500-6000 births is 40 hours per week onsite cover and at William Harvey Hospital this standard was met. The unit had 24 hour a day seven days a week cover, in September 2020 this had increased from 60 hours onsite to 24 hours a day seven days a week. Consultants were on call during evenings and weekends. Out of hours, consultants covered from home and could access information remotely. Staff told us consultants attended swiftly when called in.

The medical staff matched the planned number. Consultants were supported by eight obstetric registrars who covered delivery suite, day care, the Folkstone ward and when on call the emergency and gynaecology department. This was important because the care group had seen an increase in women with complex needs.

Anaesthetists were available 24 hours a day seven days a week to cover the delivery suite theatres. This meant that women had timely access to invasive care in the event of an emergency. Anaesthetists had planned elective caesarean section sessions each day and ran clinics to review

The service had low vacancy rates for medical staff. Records showed the current vacancy rate was 3.38%.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction before they started work. As locums were not contracted and may rotate to different hospitals, the service found the need to make sure they practised safely. The trust created a 'Locum Policy' to make sure managers followed a clear process for employing, inducting and orientating locum doctors, which included a competency checklist to be signed off by their assigned manager.

Records

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

Women's notes were comprehensive, and all staff could access them easily. Records contained evidence of women's choice, risk assessments, mental health assessments and individualised care plans. The seven sets of records we assessed were not always contemporaneous; timelines and care plans were not easy to identify. This meant record reviews were time consuming and may lead to staff missing important information.

The trust had recently acquired access to the regional area NHS care record spine. This was important because there were times when staff needed to confirm a woman's history. This system accessed the health records of the local population, including their GP and hospitals records, their allergy status and any recent safeguarding concerns. Staff could access this information immediately, although community staff were not aware that these records were available.

Records were stored securely, access to the digital maternity records was password protected and staff accessed information on a need to know basis. Managers could identify which staff had accessed notes and when, which ensured procedures conformed to current general data protection regulations.

When women transferred to a new team, staff could access their care records. This was because women carried a copy of the records which were called 'the handheld notes' to each appointment during pregnancy. This meant that staff had access to care provided even if women moved to other locations.

However, staff did not always record a lead consultant in the mothers maternity care record; a recent review by the trust found that a named consultant was missing from 50% of records during the reporting period; the trust planned to monitor this over the coming year.

The Women's Health care group used a mixture of paper and electronic medical records across all aspects of care. Staff worked on four separate digital systems, to admit, access care, update records and review recent history. This was time hungry; this matter was on the trusts risk register.

Maternity

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Within the last year the trust had implemented a digital system for prescribing, recording and monitoring medication which could be accessed across William Harvey's maternity unit. Staff had access to the most recent guidance online so they could safely administer medication.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs were stored separately to other medication and staff access was by a key-coded lock and a key. Controlled drug logbooks were kept nearby and contained patient information and stock levels in line with regulations. Documentation we reviewed confirmed records were accurate and up to date on the delivery suite.

Staff followed trust operating procedures for the prescribing and administration of medication within the unit. Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. On the ward we saw staff reviewing women's medicines regularly, and completing routine identity checks before given medication to midwives.

Managers had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Two staff members were required to dispense, check and administer controlled drugs throughout the maternity unit in line with national legislation.

All new midwives completed a medicines management competency prior to their employment with the trust. However, staff were not expected to complete a yearly medicines management competency to reduce the risk of medication errors.

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

However, on the ward there were days when controlled checks were missed so we raised this issue with the service so they could investigate and rectify this.

Incidents

Leaders had made improvements to how it managed patient safety incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. Although, not all staff understood why incident reporting was important.

Staff knew what incidents to report and but did not always take time to report them. Staff told us that they did not report all incidents around staffing, and unit capacity issues. Between January and June 2021, there had only been seven incident reports for unsafe staffing. Staff felt continually reporting short staffing had not improved the situation, so they had stopped reporting this.

Maternity

The unit used a standardised reporting tool accessed online, and staff knew how to access it. A lead midwife for risk checked the reporting and investigation of all incidents across both maternity units. They handled audit data, reviewing policies, key performance targets, investigations and fed-back concerns to the lead for risk and governance.

Most staff raised concerns and reported incidents and near misses in line with trust policy. The care group reported serious incidents relating to maternal death, intrapartum stillbirth and early neonatal death following the Serious Incident Framework 2015. The data confirmed that from July 2020 to June 2021 the trust reported 21 serious incidents (SI) in maternity which met the reporting criteria set by NHS England. This was slightly above the expected target of 19. Stakeholders were inspecting reviews and actions to help improve care.

Managers thoroughly investigated incidents. There was evidence that changes had been made as a result of feedback. Managers had created a system to holistically review incidents. Women and their families were involved in these investigations. Records confirmed that serious incident deep dive reviews were completed to identify trends and learning. Reviews included the topics of stillbirths, babies who had oxygen restrictions during childbirth and were sent for a treatment called cooling and neonatal deaths.

Trust data for July 2021 confirmed that for the reporting period the trust had 287 open incidents, the trust did not provide a rationale for why so many were open.

The care group had zero “never events” on any wards. Staff told us that managers would share learning from never events with their staff and across the trust.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. If something went wrong, staff gave families the contact details of a member of staff so they could be debriefed when they were ready. Families were involved in the sign-off of the investigation reports, any questions answered within the investigation process.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff understood the importance of shared learning from incidents. Once incidents had been reviewed the staff member raising the incident received an email to confirm this.

Staff had the opportunity to meet to discuss the feedback and look at improvements to patient care. Risk meetings were held every Tuesday so that staff could collectively review cases using the available evidence and share learning. Although, due to lack of staffing midwives told us they rarely got the chance to attend.

The trust reported severe brain injury diagnosed within the first seven days of life to the Healthcare Safety Investigation Branch (HSIB).

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

Maternity Dashboard

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

Maternity

The maternity dashboard was not displayed on all wards for staff and patients to see the outcomes of care within the care group. For example, in the community setting and day care.

The maternity dashboard showed the service had reduced the incidence of harm within the reporting period. Trust targets were set to reduce poor outcomes for mothers and babies. Staff used the safety thermometer data to further improve services. Although, current data sets confirmed a rise in stillbirth rates which exceeded the national average.

Is the service effective?

Inspected but not rated

Patient outcomes

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

The care group participated in 39 relevant national clinical audits. Managers and staff used the results to improve women's outcomes. This was important because the service was under scrutiny from several external agencies including NHS Improvement (NHSI), The Clinical Negligence Scheme for Trusts (CNST), the local Clinical Commissioning Group (CCG) the General Medical Council (GMC) the Nursing and Midwifery Council (NMC) and the CQC. Stakeholders highlighted areas of improvement, and audits were used to check the progress of changes made to the care group.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The clinical audit lead, and a compliance and patient safety midwife oversaw the implementation and monitoring of audit programs. The trust contributed to several national audits, these included the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK), the Perinatal Institute audit (fetal wellbeing), National Perinatal Mental Health and National Pregnancy in Diabetes (NPID).

Managers and staff used the results to improve women's outcomes. Improvements were checked and monitored by the care group. The maternity dashboard reflected Royal College of Obstetricians and Gynaecologists (RCOG) good practice guide. The dashboard confirmed that the staff checked several aspects of care; for example, vaginal births, induction of labour and blood loss over one litre. Current data confirmed that the trust had struggled to reach most targets during the reporting period.

The trust had a lead for antenatal and postnatal screening who monitored public health indicators and records confirmed that the trust had achieved local targets within the reporting period.

The care group contributed to the national “Diabetes in Pregnancy” audit. Diabetes in pregnancy can lead to catastrophic outcomes for babies, as it increases the risk of stillbirth. Staff recruited women to be involved in the audit which meant the data was only as accurate as the women involved. The audit found gaps in specific diabetic led care with only half the women seen in the joint diabetic clinic. As a result, the trust implemented quality improvement measures to address the gaps in care.

Maternity

Outcomes for women were positive, consistent and met expectations, such as national standards. For example, managers adopted the obstetric anal sphincter injury (OASI) care bundle which is a set of interventions to reduce the risk of perineal trauma. Managers monitored 3rd and 4th degree rates to improve outcomes for women. The current NMPA target is 3.5% and records confirmed that during the reporting period the trust performed well, outcomes were consistently below target on average 2.7%.

The number of women who had a second caesarean section was 25% lower than all the other organisations who supplied data, 65.1 compared to 83.5 nationally and 80.9 for MBRRACE-UK contributor trusts.

Managers monitored the readmission for women who had a caesarean section and made sure the outcomes were used to update practice. Current data showed the trust readmission rate was not exceptional and currently below the trusts target of 4.7%.

Staff checked the number of babies born before arrival (BBA) of a midwife or obstetricians. Records confirmed from January 2021 to June 2021, 20 babies were born without the support of a healthcare professional.

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

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

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

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

However, the trust did not always act on the data or the outcome of audits were not always fedback to staff. For example, managers collected data to support higher risk women at all booking appointments. This included women's ethnicity, postcodes to highlight social deprivation or other risk factors such as a high body mass index. Records confirmed that only 1,950 pregnant Black, Asian and Ethnic Minority (BAME) women, out of 5,750 had a medical risk assessment completed at every appointment. It was unclear what actions have been put in place to improve this, as we did not see this discussed in the minutes we looked at.

Competent staff

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.

Maternity

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The trust offered all newly qualified staff a preceptorship programme. Staff told us their competencies were monitored and signed off by senior staff to ensure practice was embedded.

Managers gave all new staff a full induction tailored to their role before they started work. The induction programme included mandatory training and a period when staff worked supernumerary. Staff told us that this helped them safely orientate to new environments.

The trust monitored appraisal rates. The current appraisal rate for midwifery staff was 71%, this fell short of the trust target of 90%. Staff sickness, COVID-19 self-isolation rules and staff shortages were the main themes that prevented all staff being appraised on time.

Managers supported staff to develop through yearly appraisals of their work. Matrons signed up to a leadership programme which started in January 2021. All Band 7 midwives had commenced on a development programme to enhance their leadership skills.

Managers made sure that community midwives received newborn life support (NLS) training. This was because they attend births at home. A recent incident had highlighted delays in calling for help at a homebirth. Records confirmed that 94.8% of community midwives were compliant. The trust had identified gaps in NLS training and worked hard to make sure all staff were compliant with training by September 2021.

In response to an incident, the trust had employed a fetal wellbeing midwife to improve knowledge and skills and embed training. They monitored CTG interpretation, supported staff throughout the unit and updated staff training.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. Professional midwifery advocates were responsible for reviewing practice and supporting staff identified as needing extra support. Each professional midwifery advocate had a caseload of 30 midwives, who they meet with once a year to complete revalidation and restorative clinical practice to support staff following an incident. Each professional midwifery advocate were allocated 7.5 hours a month to undertake this role.

Obstetric consultants supported medical staff to develop through regular, constructive clinical supervision of their work. Consultants reviewed doctors progress and made sure that medics were involved in audits and incident reviews to increase their skills and knowledge.

Obstetric staff told us that over the last few years from 2018 onwards the faculty of education collaborated with Oxford University and implemented a robust training structure that included human factors training. During the pandemic, medics completed virtual skills and drills training and multi-professional obstetric emergencies training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The practice development midwives (PDM) supported the learning and development needs of staff. Practice development midwives worked across both sites to develop and implement training. They used themes identified through incident reporting to update teaching sessions.

Managers made sure all staff were invited to team meetings or had access to full notes when they could not attend. This was because COVID-19 social distancing rules had meant meetings were moved online. Staff told us that they did not always attend because meetings were held outside working hours.

Managers identified poor staff performance promptly and supported staff to improve. Staff who had missed training updates or who had been identified as needing extra support were offered supernumerary support within the unit to expose them to updated practice to increase knowledge skills and confidence.

However, staff who were asked to work in areas they were not familiar with reported having a poor induction or orientation, leaving them underprepared which affected their ability to perform effectively and safely.

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

Multidisciplinary working

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

Staff at the hospital held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff shared key information to keep women safe when handing over their care to others using the SBAR (situation background assessment risk) tool. Safety huddles were conducted in the delivery suite. Obstetricians, midwives, paediatricians, neonatal nurses and anaesthetists attended the morning huddle. Staff discussed basic information that included staffing, acuity of patients and capacity.

Doctors held daily ward rounds to assess the mothers condition and review care plans. Managers had created a standard operating procedure for consultant led ward rounds, and evidence of multidisciplinary (MDT) ward rounds had been recorded since December 2020. Staff followed a handover of care policy.

The maternity unit had a daily maternity operational manager who was contactable via a bleep. There were daily on call midwifery, obstetric and paediatric managers. Staff were able to contact them if they needed extra advice or support when caring for women.

The service provided combined specialist antenatal clinics. Consultants specialised in a range of women's medical health conditions. These included diabetes, mental health, twin pregnancies and women requesting a vaginal birth after a caesarean.

Staff worked across health care disciplines and with other agencies when required to care for women. Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Women were seen in a joint clinic by a consultant and a specialist midwife. Although they were not always cared for by the trusts vulnerable women team.

A critical care outreach team worked across the trust, in the event of an obstetric emergency shift co-ordinators could put out an emergency call and the outreach team would be contacted to respond.

Anaesthetists held antenatal clinics to review patients who had co-morbidities, to make sure they were assessed prior to labour or an elective section. This was to make sure these women could tolerate anaesthetic medication safely.

Maternity

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

Midwives worked in partnership with neonatal colleagues on the ward and in the Neonatal Intensive Care Unit (NICU). The Folkestone ward cared for moderate risk babies and communicated with neonatal nurses effectively.

However, we found that the community midwifery teams did not have daily huddles and were not included in daily huddles that occurred across both sites. This meant managers lacked oversight into the challenges within the community setting.

Is the service well-led?

Requires Improvement 

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

Leadership

The leadership team had the skills and experience to run the care group and they supported staff to develop their skills and take on more senior roles. But they did not always understand and manage the priorities and issues the service faced. Not all of them were visible and approachable around the hospital for patients and staff.

On the week of our inspection a new interim director of midwifery (DOM) commenced employment; and was being orientated to the care group and the challenges that the women's health division currently faced. This fresh eye approach had the potential to drive and embed the changes required to improve services.

There were systems in place to monitor the care group; because the board supported by stakeholders reviewed the quality and safety of maternity services at the acute sites. Records confirmed that the HOM had access to a board level executive and a non-executive director (NED) had been recently appointed. Their responsibility was to work collaboratively with the board level safety champion in chairing the maternity improvement committee and Clinical Negligence Scheme for Trusts (CNST) review panel.

The divisions management structure was under review. The care group triumvirate was clinically led by the clinical director (CD), DOM and operations director. Currently the DOM was managed by and reported to the recently appointed chief nursing officer (CNO) on a weekly basis.

The CNO held weekly meetings with the DOM and heads of midwifery (HOMs) to provide ongoing support, guidance, review services and oversee improvement and action plans. The CNO met monthly with the regional midwifery officer.

The care group held leadership workshops and invited all staff to meet the triumvirate to share updates, concerns and successes. Clinical leads attended a clinical leadership development programme, working with the Faculty of Medical Leadership and Management (FMLM) through association with consultant staff to review and strengthen medical appraisal.

Maternity

The trust encouraged leadership development for heads of nursing/ midwifery, midwifery matrons and band 7 staff. Matrons were enrolled on the leadership programme which started in January 2021. Managers told us that this programme enhanced their knowledge and skills and helped them to have a full oversight of the challenges of the service.

Managers were visible through the unit; staff knew who they were and how to contact them. The acute matron oversaw services and had an open-door policy. Staff told us they were approachable and supportive.

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

Some staff raised concerns about lack of visibility of the care group triumvirate. Staff felt they did not fully understand the impact of the operational issues on staff wellbeing. Because of this staff were reluctant to raise issues or concerns and report incidents. This disconnect increased the likelihood of a lack of oversight, placing women and babies at risk of significant harm. When we fed this back to the recently appointed DOM, they were available to visit the triage area and review the challenges. This acted as an assurance to staff that their voice was being heard within the unit.

Following the inspection, we asked the care group triumvirate to review staffing, care and treatment and governance processes because we found areas of unsafe practice. Their response was swift, and we received a quality action plan which included time frames for deliver. The new leadership teams focused on driving the changes required to improve services.

Vision and Strategy

The care group 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.

The care group had a vision of what it needed to do to make improvements and there had been a recent change in strategy to develop the actions and embed these into practice. The trust had implemented the 'We Care' programme which was due to be rolled out to maternity in September 2021. The model shaped and embedded a patient safety culture at clinical level to deliver sustained improvement throughout the trust.

The new maternity non-executive director was responsible for overseeing and monitoring the implementation of the new strategy. The care group shared decision-making and a recent senior level recruitment programme employed fresh eyes through leadership risk and governance. The team was developing their capability and competence around decision making, to build a new cultural approach to care.

However, obstetric staff felt there was no clear vision for the future, that care was driven by targets and the trust was trying to achieve this with minimal staff. This was because the care group had gone through several stages of organisational change and there was a change in the leadership structure.

Maternity

Culture

Not all staff felt respected, supported or valued; but they were focused on the needs of patients receiving care. Not all staff felt that the service promoted a culture of equality and diversity in daily work or provided opportunities for career development. However, leaders recognised the culture needed to improve so that patients, their families and staff could raise concerns without fear.

The service had not always listened to staff feedback. Many staff felt unsafe in their working environment and excluded from the decision making around improvements; the last staff survey confirmed this. We found evidence of a disconnect between the executive team and the care group triumvirate and operational staff was evident in the recent staff survey. Although 85% knew who senior manager were, only 27% felt senior managers acted on staff feedback. In addition, 41% felt communication between senior management and staff was effective and 30% felt senior managers involved staff in important decisions.

Staff did not always feel comfortable to raise concerns if they were unhappy about how services were managed. Staff said that there were times when they felt undermined and belittled for raising issues around fatigue and safety.

Staff did not feel that the organisation took positive steps to act upon health and wellbeing concerns. Staff had worked in an extraordinary challenging condition during the pandemic and it was clear that many staff had been deeply affected by what they had experienced. The staff survey confirmed that many staff across the trust felt unwell and stressed and had attended work when they didn't feel well enough to perform their duties.

Community midwives felt they worked in a silo, they felt detached from the acute setting and did not feel they had a voice, or that they were encouraged to be involved in changes or improvements to the service. They had been used to backfill shifts with no recognition for the long hours they were working or the impact on their health. We fed this back to the leadership team, and they responded with plans to set up listening clinics for staff.

Following high level engagement and a focus group with NHS Improvement, the chief medical officer (CMO) and chief nursing officer (CNO) commenced bi-weekly focus groups across sites during July 2021.

Managers had developed a strategy to combat cultural challenges and records confirmed that systems were in place to improve communication throughout the unit so that staff felt comfortable in raising concerns and improving safety. Monthly safety champion staff feedback sessions were held with the executive board safety champion who was the chief medical officer. The trust was expanding the freedom to Speak Up (FTSU) guardian program to support the adoption of a proactive approach to engaging with staff. The service fed-back to the national FTSU guardians office.

The care group planned to repeat a maternity self-assessment tool exercise to inform the refresh of the maternity strategy. It was hoped that this would be in coproduction with women, families and staff of all levels. Feedback from staff sessions was included in monthly oversight and assurance meetings to understand the impact actions were having at frontline. Although, the trust did not confirm how many people attended these sessions.

Women's Health had 19 cultural champions, these included nine midwives and three doctors. There were plans to increase this to 30 across Women's Health and Children and Young people care groups. The organisation development team now focused on diagnosing issues and implementing change. The diagnostic phase comprised of focus groups to identify what was working well and what needed changing. The diagnostic element was being reviewed at the time of our inspection; therefore we were unable to confirm whether it had raised awareness and encouraged staff to speak up and out.

Maternity

Medical staff told us that historically there had been a bullying culture that had affected the relationship between doctors and midwives in the past. Obstetric staff had seen this as a barrier to change. However, they had seen improvements and felt that the recently appointed clinical director would contribute to positive change.

Governance

Leaders did not always operate effective governance processes, throughout the care group or with partner organisations. Not all staff were clear about their roles and accountabilities, although they had regular opportunities to meet, discuss and learn from the performance of the service. Because of this the trust was in the process of strengthening governance across all divisions.

Historic concerns about the governance structure and the lack of oversight on incidents meant that stakeholder organisations were supporting the trust to make improvements.

Organisations worked together to improve systems and processes within maternity services. The "Quality Governance Framework" and reporting structures across the trust had recently been reviewed and reinforced. Historically the care group had not been pro-active in making sure governance structures were robust and effective and reviews of serious incidents confirmed this.

Leaders recently developed a new term of reference and the new non-executive director (NED) chaired the Quality and Safety Committee. The director of midwifery and the clinical director attended the board and board sub-committees to present maternity papers and provided a professional voice for midwifery/ obstetricians.

Kent and Medway Local Maternity System (LMS), NHS England, the regional chief midwife and CQC met monthly with all maternity trusts across the unit to discuss the wider maternity health economy. The challenges at William Harvey Hospitals maternity unit were reported to the team and plans were made to mitigate current risks. During our inspection we saw that William Harvey maternity unit was understaffed and patient care was compromised. The LMS advised us that all trusts within the region were experiencing staffing issues that related to COVID-19, self-isolation and staff sickness. Because of this the trust were advised to cease their homebirth service and re-open their Maternity led unit to ensure safer care for women and their babies.

A new director of quality governance (DoQG) had been recently appointed at the trust; they had significant experience in improving quality governance systems in healthcare. Part of their remit was to prepare the trust for the updated Patient Safety Incident Response Framework which is being rolled out across the Country.

Leaders had reviewed the serious incident process across the trust. The trust had implemented a multi-disciplinary review against the serious incident framework; this was achieved by increasing the frequency of panels across three main sites to meet regulatory timeframes and ensure immediate actions from incidents were taken. The DoQG provided daily touch point calls to the maternity governance team to provide support and oversight. During these calls new incidents were reviewed designated staff were being mentored on how to review incidents and draft reports.

The serious incident and risk team reported to the quality committee monthly and used a standardised governance template. The clinical commissioning group deputy chief nurse and regional chief midwife reviewed and provided feedback on 72-hour reports to support education and learning to the maternity governance teams. This process had a positive affect and gave staff the ability to identify and address immediate concerns.

Maternity

Maternity and neonatal serious incident cases were now shared with the improvement director, and external groups were notified directly. This was because the care group had not always reviewed these incidents correctly. Regular executive-led care group meetings had been implemented to review action plans and ensure progress. Also reporting tools for use in the trust were being developed in compliance with the Perinatal Quality Surveillance Model.

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

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

However, not all staff understood the process for reviewing incidents and drafting reports. The clinical commissioners, head of patient safety and learning and associate director for nursing and quality; implemented training sessions on incident reporting, management and learning, were offered to key staff. Experienced staff we spoke to had limited knowledge of the process and felt it would help their development if they had more insight into the process.

Governance processes had failed to provide oversight and assurance of postnatal care within the community; this included first home visits and the assessment of neonatal jaundice. We raised this as a concern with the trust who recognised that it had failed to implement the most recent guidance. They made plans to immediately reinstate first home visits to assess mothers and babies thoroughly.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events but did not always have the capacity or staffing to implement those plans. Not all staff had the opportunity to contribute to decision-making to help avoid financial pressures compromising the quality of care.

Managers, benchmarked performance using data collected via the maternity dashboard. Data confirmed that the unit had reported a high stillbirth rate during the pandemic. Poor outcomes for neonates were under the national average.

Leaders kept and updated a maternity risk register. Current risks included one to one care in labour, overheating on the wards during the summer and violence and aggression from mothers, and their families towards staff. Also, the Clinical Commission Group (CCG) risk register recorded a risk that the trust did not have the capacity or ability to make and robustly maintain the required improvements to deliver sustainably safe maternity services. Records confirmed that managers regularly reviewed and updated the risk register.

The service held risk meetings bi-monthly and these were attended by key staff responsible for reviewing and reporting risks. Agendas confirmed that managers reviewed incidents to make sure they were correctly categorised and that actions had been taken to identify themes and trends and inform future training and development.

A rapid multi-professional review had been completed of the homebirth service which included a review of the guidelines, equipment, staff training, staffing numbers and caseloads and risk assessments. The trust implemented a standard operating procedure for equipment responsibilities and management in place with a robust equipment checking schedule implemented and overseen by the community midwifery team leaders.

The reviews found gaps in knowledge and lack of equipment and support, which meant there had been a lack of oversight in the past. As a result, all community midwives had been scheduled for emergency neonatal life support training updates from April 2021. At the time of writing 70% of community midwives had completed this. Also, managers updated the home birth and care outside of guidance guidelines and a homebirth risk assessment tool, but these had only recently been implemented.

The trust failed to recognise the impact of the increase in mothers telephoning the service for advice and support. They stopped auditing calls, including the acuity / complexity of the calls and how this had an impact on staff workload. Answering the telephone took time, and this part of the work had not been factored into the staffing acuity tool. This meant there were times when non-clinical staff took calls and triage patients with limited experience. Midwives acknowledged that care had to be rushed because the telephone calls had eaten into time to assess patients who were already onsite.

There was a lack of oversight on how much work maternity day care, triage and community midwives were expected to complete. Staffing numbers had not been reviewed properly, because managers had not looked at the service as a whole and had not factored in the impact of the COVID-19 pandemic on staffing. Lack of staffing was a known risk flagged by the Local Maternity Systems (LMS) across all maternity units across the region.

Leaders did not always balance the risk and benefits of long-term decisions. During the pandemic leaders made the decision to close the midwifery led unit due to staffing issues. This had a negative impact on community midwives because staffing across the trust was already low. The community teams saw an increase in homebirths, because women could not access the midwifery led units and because managers at the acute sites were using them to back fill shifts. This left staff unable to complete their routine work safely.

The trusts “Emergency Escalation” policy lacked clarity on how many hours a midwife should work safely before their judgement was deemed to be impaired by fatigue. There was no guidance for Acute site midwives to relieve the community midwives, and make sure their wellbeing was maintained to ensure they could safely care for women.

As a result of concerns raised by the CQC after the inspection, the trust implemented immediate safety actions which included the withdrawal of the homebirth service and re-opening of the midwifery led unit. This was because this option provided a safer care for women and babies.

Information Management

The trust collected reliable data and analysed it, information systems were secure, but they were not integrated. Which meant staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Maternity services collected reliable data which was analysed and reviewed via governance meetings. The trusts patient record software was designed format audit information so that staff could understand their performance.

Information systems did not integrate effectively. The service used four different systems to care for patients, these included outpatients and inpatient records, maternity care records, and electronic prescribing. The trust was aware that this posed a risk and were working towards a system that was intuitive and pool all key information together.

Managers sent information to third party organisations in line with their local policies. The service reviewed information via governance and risk meetings and collectively with other agencies.

Maternity

The trust published their Strategy for Excellence in Maternity Care in December 2020, and this was accessed online via the trusts website.

However, digital systems in maternity were old. The director of information technology, a clinically qualified person and chief nursing information officer (CNIO), worked with the digital lead midwife to create a strategy to improve the systems. However, leaders felt that the effort required to make maternity digital function well was underestimated.

Staff used the maternity dashboard to further improve services. A "Single Item Quality Surveillance Group", which included stakeholders worked with the trust. Records confirmed that actions had been implemented to make sure that learning from incidents was included in future mandatory training and practice embedded by audit and staff updates.

The service has no reported data breaches during the reporting period.

Engagement

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

A maternity improvement advisor engaged with stakeholders. They worked alongside clinical teams and focused on quality improvement and embedding change.

The recently published maternity services strategy had been developed with staff, women and their families. Women's experiences of care underpinned the drive to improve engagement and interactions with the local childbearing population.

Managers worked alongside the local Maternity Voices Partnership (MVP) Chair to improve care for women. Leaders had planned to complete a desktop review of maternity feedback in partnership with the MVP. The plan was to triangulate feedback from MVP, and the trusts Patient Advice and Liaison Service (PALS). This would include compliments, complaints and incidents.

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

The service collected feedback from women and their families when they were discharged from hospital or from community care.

The care group actively engaged with women; staff updated a social media page which provided public health messages and updates about services and care. Women who posted comments to the page received feedback within 48 hours and the page was well visited by the local population.

The trust had engaged with the MVP and women to create the 'home birth' continuity of carer teams cross-site. National reports and guidelines cite continuity of care as a key factor in improving outcomes for women. The teams provided continuity of care for a small number of women requesting birth at home.

Maternity

Maternity staff engagement in the trusts staff survey was lower than that of other services within the trust. Survey results from 2020 to 2021 did not state how many maternity staff had completed the survey and some data was missing. Although it confirmed that just over 50% of staff were comfortable and felt well supported at work.

Maternity staff had the opportunity to attend staff meetings, held virtually during the pandemic. Meetings were pre-arranged, and invites sent via email. Managers advised us that they had seen an increase in attendance, although some midwives told us they rarely attended as meetings were out of their working time. Meeting minutes were distributed via email.

The service produced a newsletter to inform staff of recent audit and incident outcomes and any new introductions to practice. The newsletter was on display on the ward and within community. However, the maternity dashboard displayed in community was dated 2018.

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

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

Maternity services had improved its contact with the public. The new co-designed maternity unit developed from this to suit patients' needs better. The service also took part in piloting a maternity experience communication tool designed for staff of all disciplines to understand the patient experience.

Learning, continuous improvement and innovation

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

The trust was committed to development and improvement for the maternity service. The Trust engaged with clinical commissioners and Health Safety Investigation Branch (HSIB) to support the upskilling of relevant staff in critical analysis and immediate actions to support 72-hour reports.

The leadership strategy involved recruiting from the current talent pool within the organisation, which included the clinical leadership, obstetric and midwifery teams to develop improvement plans and to lead the way in recognising what was required within services to improve.

The service received support from the Maternity Safety Support Programme (MSSP) which was run by NHS England and Improvement. Leaders requested support to identify a suitable buddy trust who have been through MSSP and to understand how buddying alongside MSSP was best delivered from their prior experience. A midwifery adviser from MSSP supported the trust with comprehensive review of a homebirth incident, including review of policies and guidelines.

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

Maternity

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

Outstanding practice

We found the following outstanding practice:

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

Areas for improvement

MUSTS

The maternity service

- The service MUST ensure that it completes a review of workloads across day care and community to be assured that there are enough staff to safely care for women and their babies. (Regulation 18 - Safe Staffing (1))
- The service MUST ensure that it reviews the escalation policy and provides clear guidance to the expectations of safe working hours for on-call staff called into cover the unit so that community midwives are not working excessive hours that lead to lethargy and neurological impairment. (Regulation 17 – (1) (2) (a) (b)(c)).
- The service MUST ensure that midwives working in the community have the required competencies and knowledge to autonomously assess and care for women and babies and make informed decisions regarding their care**. (**Regulation 12. Safe Care and Treatment – (1) (c).
- The service MUST ensure that it implements daily community midwifery huddles and that the community teams feed into the trusts cross-site huddle every day so that managers have real time oversight of acuity and capacity across all areas. (Regulation 17 – (1) (2) (a) (b)(c))
- The service MUST embed an effective system to ensure that medical staff meet the trust targets for mandatory safeguarding training to protect vulnerable adults and children and young people from harm and abuse. (Regulation 12 (2) (c))

SHOULD

- The trust should monitor first home visits for new mothers to ensure mothers and babies are holistically assessed and cared for in line with national guidance.
- The trust should consider providing community midwifery teams with bilirubinometers to help them accurately assess neonatal jaundice quickly, so that babies are kept safe from harm.

Maternity

- The service should consider implementing incident reporting and review training to all midwives, to nurture a culture of active reporting and learning from incidents themes and trends.
- The trust should complete a review of the virtual consultations standard operating procedure to ensure that pregnant women and new mothers are appropriately assessed.
- The service should make sure that it monitors telephone calls from women using the service so that midwifery staffing can be adjusted to ensure qualified staff conduct telephone assessments.
- The service should consider monitoring the use of the SBAR tool so that staff use it effectively and practice is embedded.
- The service should scrutinise data regarding ethnicity and ensure that the findings are used to inform practice.

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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