Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Maidstone Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Maidstone Birthing Centre.

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

The Maidstone Birthing Centre provides maternity services to the population of Maidstone and Tunbridge Wells and the surrounding areas.

Between May 2023 and September 2023, 155 babies were born at Maidstone Birthing Centre.

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

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

This location was last inspected under the maternity and gynaecology framework in 2015. Following a consultation process CQC split the assessment of maternity and gynaecology in 2018. As such the historical maternity and gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for safe and well-led from this inspection will be the first rating of maternity services for the location. This does not affect the overall trust level rating.

Our rating of this hospital stayed the same. The hospital is rated Requires Improvement.

Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as requires improvement and well-led as requires improvement.

There are two other maternity services run by Maidstone and Tunbridge Wells NHS Trust.

Our reports are here:

Crowborough Birthing Centre – https://www.cqc.org.uk/location/RWFX1

The Tunbridge Wells Hospital at Pembury - https://www.cqc.org.uk/location/RWFTW

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

Our findings

We visited the midwifery led birthing centre.

We spoke with 5 midwives and 1 support worker. There were no women and birthing people admitted into the birthing centre during the inspection. Therefore, we were not able to speak to any women and birthing people.

We reviewed 6 patient care records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

We rated it as requires improvement because:

- Not all staff had training updates in key mandatory skill including neonatal life support, safeguarding and competency-based assessments on the use of cardiotocography.
- Information was not always entered correctly into maternity records.
- There was a lack of risk assessments for women and birthing people choosing to birth at the birthing centre.
- The maternity service governance processes and information systems did not fully identify and manage incidents, risks, and performance to reduce the recurrence of incidents and harm.
- There was a lack of clinical audit to check any improvement needed had been achieved.

However:

- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff understood how to protect women and birthing people from abuse, and managed safeguarding concerns well.
- Staff understood the service's vision and values and how to apply them in their work.

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

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

Staff were not always up to date with mandatory training. At Maidstone Birthing Centre mandatory training compliance did not always meet the trust target for all modules. Managers monitored staff's mandatory training and staff told us they were alerted via emails when they needed to update and renew their training. However, the system was not always effective.

The trust told us the target for mandatory training compliance was 85%. Midwives were 85.7% compliant for basic life support training. However, on reviewing the data we found healthcare assistants on the unit did not meet the current recommendations and were below the required levels at 80% compliance for basic life support.

From the data received not all midwives had attended the neonatal life support training. Neonatal life support training is an important aspect of multi-professional training for clinical staff.

Maternity

National guidance required all clinical staff working on maternity to take part in simulated obstetric skills and drills training. Training was delivered by a multidisciplinary team which included obstetricians, anaesthetists, neonatologists, fetal wellbeing and fetal surveillance midwives, clinical skills facilitators, specialist lead midwives and obstetricians. The service was 92.9% compliant in PROMPT (obstetric emergency multidisciplinary training).

Staff on the unit told us they had not had any pool evacuation or baby abduction skills training at the birthing centre. Training data received from the service for emergency pool evacuation procedure included all maternity staff across the trust, therefore the trust did not confirm if all maternity staff working at the birthing centre were training compliant. The training figure for all maternity staff across the service was 84.9%, which was just below the trust target of 85%. Midwives working within the birthing centre did not have immediate access to emergency support staff as on an acute ward. Therefore, pool evacuation training compliance was important to ensure midwives were competent in the emergency evacuation process. During the factual accuracy process the service told us midwives were provided with a virtual training presentation on pool evacuation and baby abduction however, this does not take the place of emergency skills and drills practice in situ.

The trust's corporate induction included medicines management. Not all midwives had completed the corporate induction with only 75% of midwives compliant.

Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour were competency-based assessments. We received combined training data for the two birthing centre locations. This showed staff were below the trust target with 76% compliance.

The service had a team of specialist practice development midwives who had oversight of training and development. The team was led by the consultant midwife and consisted of three midwife practice facilitators and two practice development midwives.

The practice development team (PDT) produced a monthly maternity update which identified current highlights within the team for development, key pressures, key development and what support or action was required from the senior leadership team. The service monitored staff training attendance through the clinical risk management group and compliance reports were submitted monthly by the practice development team.

The key pressures identified within the October 2023 report were issues with getting staff booked onto mandatory training, staff not attending, and a lack of room space for training. The education centre within the trust could not provide sufficient bookings to run PROMPT training as often as required and there was a lack of protected, funded training time for midwives. The service had a maternity core training programme to meet the requirements of the core competency framework developed by the maternity transformation programme.

Core modules for staff training included Saving Babies Lives Care Bundle, fetal surveillance in labour, maternity emergencies and multi professional training, personalised care, care during labour and the immediate postnatal period and neonatal life support.

Maternity training was formed by local learning from incidents, audit and staff and patient feedback. Practice development teams worked closely with the maternity governance team to look at themes or trends and training programmes were adapted to include national updates and local outcome data. Following all live training sessions, a summary of the learning points was shared with all staff in attendance, as well as the obstetric risk review meeting if required.

Maternity

The maternity service had a training strategy which set out all training requirements for maternity staff. The strategy stated staff working within birthing centres were required to attend further training on maternal collapse/massive haemorrhage including cannulation, anaphylaxis, use of the automated electrode defibrillator (AED), extended neonatal resuscitation and transfer procedure, and emergency evacuation from the birthing pool.

Safeguarding

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Most staff had the training on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse. The level of safeguarding training reflected the trust's policy and in the intercollegiate guidelines. Training records showed that staff had 100% Level 3 safeguarding adults training. However, midwives were below the trust target of 85%, with safeguarding children level 3 training with only 78.6% completing the training.

Safeguarding training updates were delivered by the safeguarding specialist midwife and covered within the expected modules for safeguarding level 3 training including how to recognise and report abuse. Midwives completed safeguarding training alongside social care staff to improve interagency communication and collaborative working.

Staff told us how they identify adults and children at risk of, or suffering, significant harm and how they worked with other agencies to protect them. Staff told us women and birthing people were asked about domestic abuse at booking and at each contact. However, we did not see the evidence of women and birthing people being asked about domestic abuse in the patient records at each antenatal appointment. During the factual accuracy process, the service told us antenatal care was not provided by birth centre staff.

Staff told us that they knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could contact when they had concerns. The birthing centre followed the maternity service safeguarding policy, which included a safeguarding flow chart for the referral process and detailed contacts for the safeguarding team and the local authority safeguarding teams.

Mental Capacity Act training data showed 100% of staff at Maidstone Birthing Centre had completed training. Midwives completed the perinatal mental health e-learning training as part of their induction period and their mandatory training. The training included maternal health disorders, risk assessment and referral routes.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff we spoke to knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward. The service had an in-date baby abduction policy. However, staff told us there had not been an abduction drill at Maidstone birthing centre. Therefore, the service could not be assured staff were confident in the process and were competent to prevent baby abduction.

Cleanliness, infection control and hygiene

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

The Maidstone Birth Centre was visibly clean and had suitable furnishings which were clean and well-maintained.

The birth centre had dedicated domestic staff during the day with maternity support workers and midwives cleaning areas such as the delivery room if required during the night. We saw 'I am clean stickers' in all areas and on all equipment. Cleaning performance audits were completed, and audits showed that all areas were cleaned regularly.

The service had effective processes to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and saw action plans developed to improve compliance with infection prevention and control standards. Actions were monitored through the divisional infection prevention and control meetings.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed 'bare below the elbows' guidance. Each birthing room had hand wash sinks and alcohol hand gel dispensers.

The service completed a bi-monthly directorate report to the infection prevention and control committee. From June 2023, following a peer review from a neighbouring service, the service introduced a more formal process for capturing data from infection control audits.

The service had a star rating escalation system for cleaning audits, with 5 meaning the area had achieved its target score. We saw data which showed us from August 2023 to October 2023 the birthing centre had achieved 5 stars.

Data provided by the service showed maternity staff were 100% compliant with the infection prevention and control (IPC) training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all emergency equipment was held securely.

Maidstone Birthing Centre was situated in a stand-alone unit behind the main hospital locations. The birthing centre was opened in 2011 and was specifically designed to meet the needs of women and birthing people. The birthing centre had 2 birthing rooms both with birthing pools, chairs, and equipment and 4 postnatal rooms. Three rooms contained double beds and one had twin beds. All postnatal rooms were large, air conditioned, nicely decorated and well maintained with a next to me cot for baby. Birthing rooms had adjustable ambient lighting and equipment to play music.

Maternity

The security system at the front and back of the building was not working during the inspection. However, the service had mitigated risk by having 24-hour security guards placed at both entrances. The front entrance led you to rooms used by community teams for both antenatal and postnatal care. Access to all other areas was through a card entry system only. The premises were also monitored by CCTV. Staff told us they never lone worked within the birth centre.

The service had suitable facilities to meet the needs of women and birthing people and their families. The birth partners of women and birthing people were supported to attend the birth and provide support and there was no restriction on the number of birth partners allowed. Partners could stay overnight, and siblings were able to spend time and visit. There were facilities for women and birthing people and their partners which included a large kitchen/dining area, a garden room for women and birthing people to relax. There was also a secure enclosed patio/garden area which women and birthing people could use in labour or postnatally. The centre also had free car parking spaces.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

Staff regularly checked birthing pool cleanliness. All water outlets had an automatic flushing system to prevent the spread of legionella and the estates team visited regularly to test the water supply for legionella.

All birthing rooms had piped oxygen and nitrous oxide, as well as portable cylinders which were securely stored. Midwives were tested earlier in the year for nitrous oxide exposure and no high readings were found.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Emergency equipment was not stored within the Resuscitation Council (UK) guidelines with the drawers closed using a tamper evident tag. This meant the resuscitation trolley draws could be accessed by unauthorised people.

There was a spreadsheet to tick if the emergency equipment had been checked. This was completed daily. However, we found not all equipment was kept in the designated draws of the trolley as per the checklists and therefore items appeared as missing; a senior midwife told us the items were actually not kept on the trolley but kept in a separate bag. They informed us that all staff were aware of where all emergency equipment was stored. There was no system to alert staff of out of date or missing equipment or to confirm when resolved.

The birthing centre had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, both birthing rooms had birthing balls, mats and stools to support movement in labour. Pool evacuation nets were in both delivery rooms.

All new equipment underwent acceptance testing and was placed on an asset database which generated a schedule for preventative maintenance.

Assessing and responding to risk

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

Maternity

Risk assessments were not always completed well enough to assess the suitability and safety of women and birthing people wanting to deliver in the birthing centre.

A review of incidents at the birthing centre showed there were times when women should have been risk assessed more thoroughly prior to giving birth at the birthing centre, for example, static growth of baby.

During the inspection we requested a copy of the standard operation procedure (SOP) for Maidstone Birthing Centre. This was not provided during the inspection and staff we spoke to were unclear of the current guidance used.

However, the Maidstone Birthing Centre used a birthplace options assessment form and a birth planning proforma to review women and birthing people's past and current medical, obstetric, and social history to identify suitability for using the birthing centre. This was completed by a midwife at the antenatal booking session either at the birthing centre or within community clinics.

Staff told us the process they followed for risk assessments at each contact with the women and birthing people to ensure they were allocated to the right pathway, and the correct team were involved in leading and planning their care. All women and birthing people who wished to use the birth centre, but did not meet the guidance, were reviewed by a consultant midwife or obstetrician and a multidisciplinary team plan put in place, which was reviewed regularly with the woman or birthing person and consultant midwife.

We reviewed 4 maternity care records during the inspection and in each record, we saw risk factors identified at the booking appointment and risk assessments were completed at each maternity contact.

The service had an escalation prompt card for information given to women and birthing people during the birth plan assessment on emergency transfer statistics at Maidstone Birthing Centre. The information was compiled in collaboration with an ambulance trust to highlight the response times of ambulances attending the birthing centre for emergency transfer for women and birthing people and their babies. This was in relation to the Ockenden report 2022 which identified all women and birthing people who choose to birth outside of a hospital setting must receive accurate advice regarding emergency transfers.

Staff appeared confident and told us the processes for reviewing women and birthing people wanting to attend the birth centre and the escalation and emergency transfer pathway. Staff had told us they had received a verbal emergency transfer skills training, although there had not been a live drill for birth centre staff. During the factual accuracy process, the service provided evidence of an emergency skills day co-delivered by the local ambulance service. This emergency training day covered care of women and birthing people and babies in the community setting in scenarios such as breech birth, newborn life support and useful knowledge for 999 calls. However, the service said 5 out of 16 birth centre midwives had completed this training, which equates to 31% of staff. This was not enough for the service to be assured it was safe.

Following the inspection, the trust provided the inspection team with clinical guideline criteria for giving birth in the birth centre or at home. The criteria was dated, clear, and provided guidance around the planning processes of women and birthing people using the birthing centre. The guidance contained a link to maternity care requests outside of guidance.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The service had both an antenatal and postnatal situation, background, assessment, and recommendation (SBAR) transfer

form in place which detailed information such as time ambulance was called, time of ambulance arrival to the birthing centre and ambulance departure time and arrival time at the destination. We were told the service completed an audit of compliance with SBAR completion to identify patterns in delays and to identify potential risks. We requested a copy of the audit to review against risk, but this was not provided.

The service used a nationally recognised tool called Maternal Early Obstetric Warning Scores (MEOWS) to enable early recognition of deterioration in health. The service incorporated MEOWS audits within the maternity sepsis audit, therefore it was not able to identify whether staff were using MEOWS to identify risk. However, following the inspection of the consultant led unit, the trust had added a separate MEOWS clinical audit to their audit programme.

Staff knew about and dealt with any specific risk issues. Midwives used intermittent auscultation to listen to the fetal heart rate during labour. However, we did not see any evidence of intermittent auscultation audits within the data requested and the audit was not listed on the Women's services clinical audit programme.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

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

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn early warning trigger and track (NEWTT) tool was designed to be used by healthcare professionals working in areas caring for newborns in the early postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service had recently added NEWTT audits to the maternity service audit programme.

Midwifery Staffing

Staffing

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

The service had enough nursing and midwifery staff to keep women and babies safe. Each shift was staffed with two midwives, usually a band 7 and band 6 midwife, and a maternity support worker.

The birth centre ward manager was a shared job role, with both ward managers also working clinically. The ward managers provided overall management for the birthing centre including staffing and reported to the matron for the birthing centre and the head of midwifery.

Staff worked closely with the consultant midwife who provided overall clinical leadership and support. The band 7 midwife on duty provided clinical leadership and management for the birthing centre.

Staff told us that all women and birthing people attending the birthing centre were provided with 1:1 care in labour, although the service did not provide data to support this. If the unit were short staffed, shifts were usually covered by a member of the birth centre team, and they could also receive additional support from the community midwives.

Maidstone Birthing Centre had no vacancies. The birthing centre had a budget of 16.6 whole time equivalent (WTE) staff and currently had in post 16.7 WTE. The sickness rate for staff was 13.7%, however, this was due to long term sickness.

The service presented a midwifery workforce planning paper at service board in December 2022 that proposed several maternity roles. The service employed specialist midwives to fulfil the Clinical Negligence Scheme for Trusts (CNST) safety actions, such as a mental health midwife, safeguarding midwife, practice development midwives and risk and governance midwives.

Information provided by the service did not make it clear whether 'red flag' staffing incidents were reported in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. During the factual accuracy process, the service said 'red flags' were reported and monitored through the incident reporting system.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The appraisal rate for staff was 92.9% for midwives and 100% for maternity support workers.

Records

Staff did not always keep accurate and detailed records of woman and birthing people's care and treatment. Records we reviewed during the inspection were clear, up to date, stored securely and easily available to all staff providing care.

We reviewed incidents of incorrect records placed in women and birthing peoples maternity paper records and incorrect information recorded onto the electronic patient records system. We found there were 13 out of 84 incidents in relation to record keeping. For example, incorrect weights taken at birth, the wrong notes placed into maternity records, the wrong date of birth placed on blood samples and observations not completed.

The birthing centre had a guide to basic record keeping standards in the birth centre. The guide detailed the process for intrapartum and postnatal documentation. The trust used a combination of paper and electronic records, with a plan to transfer all records onto an electronic record system.

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Women and birthing people's notes we reviewed during the inspection were comprehensive, and all staff could access them easily. We reviewed 4 paper records and found these records were clear and completed correctly. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Maternity records were not audited unless triggered by a case review, therefore there was no maternity service oversight of records. The service told us staff were encouraged to complete documentation audits for their own learning and there were proformas to support this. Post inspection we were told data collection was not supported by a formal process to provide oversight or to coordinate the outcomes. Therefore, the trust could not be assured senior leaders had actioned learning in response to the incidents around records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines and medicines training was incorporated into the mandatory corporate training for staff. However, not all medicines were stored correctly.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines administration charts for medicines needed during admission were completed in women and birthing people's hand-held records. Midwives accessed the full list of midwives' exemptions, so they were clear about administering within their remit.

Medicines were stored in a locked cabinet and were only accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

However, in the neonatal resuscitation trolley we found the neonatal emergency medicines were not stored securely. For example, there was no tag on the bag for the medicines. The card around the emergency medicines could be easily removed and medicines could be tampered with. We told senior staff who spoke with the trust pharmacy, and we were told this was how all neonatal emergency medication was stored. However, all emergency medication should be stored securely.

We saw aromatherapy oils used during labour were stored in the medicine fridge alongside medicines. This is not in line with Royal Pharmaceutical Society guidance which stated fridges used for the storage of medicines should not be used to store any other items. The aromatherapy oils had been opened so there was a potential for cross-contamination. We also found the aromatherapy oils to have no date noted as to when the bottles were opened, and all oils were out of date. We escalated this to the matron who disposed of the oils.

Incidents

The service did not always manage safety 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 birthing people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated the national Strategic Executive Information System (STEIS) if a serious incident was declared.

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Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system.

The service told us the patient safety team and maternity risk team reviewed patient safety incidents, with incidents open over 60 days, cases meeting statutory duty of candour and serious incident criteria escalated within the division. The service also had a weekly multidisciplinary risk review meeting.

There was a daily midwifery safety huddle which was attended by one of the risk team. We attended the meeting during our inspection, and we listened to an incident shared with the team for further review. Learning from incidents was distributed to the team through staff emails, newsletters, and 'GLOW' (getting learning out weekly) messages. Incident themes and trends were presented by the risk and governance manager at the monthly clinical governance meetings.

We had requested from the maternity service all incidents relating to Maidstone Birthing Centre from November 2022 to November 2023. The maternity service provided a document which listed 84 incidents which we reviewed but we found not all incidents were related to or had occurred within Maidstone Birthing Centre.

There was a further request made to the maternity service asking for clarification of incidents relating to Maidstone Birthing Centre only and we received information to show from November 2022 to November 2023 there had been a total of 50 incidents recorded.

All incidents had been classed by the maternity service as either no physical harm or low harm. Incidents included one case of a neonatal death in 2023 and not all incidents we reviewed had been graded correctly.

There were 10 incidents where harm was caused, or there was a potential of harm. We found common themes within the incidents, which included a lack of risk assessment for women and birthing people choosing to birth at the birthing centre. We saw incidents of incorrect measurements documented of the symphysis fundal heights and a lack of contemporaneous documentation from antenatal appointments. For example, there were 3 out of 10 incidences of babies who were born large for gestational age, this meant there was a potential for a higher risk outcome and post-partum haemorrhage (PPH).

There were 12 incidents which identified staff at the birthing centre had completed incorrect documentation including incorrect growth measurements, incomplete information completed for discharge, and incidents of staff placing patient identifiable information incorrectly into the wrong women and birthing person's records, demonstrating a breach of general data protection regulations (GDPR).

We reviewed incidents which highlighted women and birthing people who had been advised to attend the birthing centre for birth however, in several cases there was evidence that local guidance had not been followed to prevent the use of the birth centre for women and birthing people at potential increased risk of harm. For example, identification of static growth of baby, small for gestational age, and a lack of growth monitoring.

The service reported no 'never' events on the birthing centre.

The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. The outcomes from serious incident reviews were reported from the obstetric clinical governance meeting to the trust board.

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In all investigations, managers shared duty of candour and draft reports with the families for comment. However, we could not be assured managers reviewed incidents potentially related to health inequalities. Managers shared learning with their staff about never events that happened elsewhere.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

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 woman and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The service sat within the women's, children's, and sexual health division. The triumvirate consisted of the divisional director of operations, chief of service and the director of maternity.

The head of midwifery was new role, which was promoted internally. The triumvirate had told us the role was given after a year of changes and uncertainty within the midwifery service.

The head of midwifery role had recently been appointed and the service also had a consultant midwife, clinical director and general birth centre manager. Below this branch of leadership there was an interim matron for Maidstone Birthing Centre. The service also had two band 7 ward managers who job shared the role, and their hours were split between management and clinical.

Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. Maternity safety champions and non-executive directors supported the service. Maternity safety champions carried out regular visits and walk arounds at Maidstone birthing centre.

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.

There was a trust wide vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust had developed a five-year plan for the organisational vision of the trust, which was Exceptional People, Outstanding Care (EPOC). All improvement activity including projects, activities and goals were aligned to the strategy. The service used their EPOC improvement programme to provide a structured approach to support delivery of the trust's vision.

Maternity

The trust strategy was aligned to local plans in the wider health and social care economy and services were planned to meet the needs of the local population. The overarching strategy included 6 strategic themes: patient experience, patient safety and clinical effectiveness, patient access, systems and partnerships, sustainability, and people. The themes were supported by 6 strategic initiatives which included clinical, digital transformation, EPOC improvement programme and people and culture. Each strategic theme was reviewed by the board twice a year.

Senior leaders informed the inspection team that the aim was to complete the maternity strategy by 2024 following incorporation of the nursing and midwifery strategy.

The maternity service's aim was to have delivered all 10 key elements of the Better Births plan; to encourage more out of hospital deliveries; to make sure women and birthing people treated in the right place and at the right time; to increase the opportunities to transfer more services into day cases and outpatient settings; and to create a dedicated midwifery led unit at the obstetric unit.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work.

Staff were mostly positive about working in the service and its leadership team. Staff mostly felt able to speak to leaders about difficult issues and when things went wrong.

The service provided information on the NHS staff survey 2022 and staff experience surveys which were undertaken quarterly in 2022 and 2023. Maternity survey information was included within the women's directorate which also included gynaecology services. Information within the survey was not broken down into specific maternity areas.

Following on from the NHS staff survey 2022 the service carried out multi-disciplinary listening events with support from the organisational development teams, delivered a matron development programme and a senior leadership training matrix for band 7 midwives upwards. The maternity safety champions had completed walk the floor visits and the wellbeing team had visited the maternity areas to offer support to staff.

The staff survey completed in July 2023 showed scores were worse than previous survey scores across the women's directorate, with only 43% of staff feeling the trust had a genuine concern for staff safety and wellbeing, and 55% of staff feeling there were frequent opportunities for staff to show initiative in their role. However, as the staff survey was service-wide, it was not possible to identify how staff felt about culture within this location, which makes up a small portion of the maternity services provided by the trust.

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, through monthly team meetings. Staff understood their role within the wider team and took responsibility for their actions. However, we reviewed information from the rolling action log following the maternity safety champions walk the floor visit at the birthing centre completed in May 2023. This highlighted staff concerns around staff feeling isolated and not always included in the formation of policies. Staff felt anxious when short staffed and felt they were scrutinised by maternity staff at the main hospital site.

Maternity

Staff we spoke to were fully focused on the needs of women and birthing people and were keen to provide a service where women were listened to and supported in their birthing choices. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

The service had an open culture where women and birthing people and their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There had been no complaints about the care received at Maidstone Birthing Centre between May and August 2023. Staff we spoke to understood the policy on complaints and knew how to manage and respond to them.

Governance

Leaders did not operate effective governance processes throughout the service. Staff were not always clear about their roles and accountabilities, and they did not have regular opportunities to meet, discuss and learn from the performance of the service.

The service leaders did not always assess, monitor, or improve the service through effective audits or mitigate risks. There had been several changes to the senior maternity leads, with the head of midwifery recently starting in post.

Managers told us they supported the flow of information from frontline staff to senior managers, with the head of midwifery and consultant midwife leading on governance within the maternity service. The service also had an interim matron for safety and governance and a matron for maternity transformation which was a new role within the service. Maternity service performance reports were shared within the women's, children's, and sexual health divisional monthly board meetings. Staff knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Leaders did not always monitor key safety and performance metrics through a comprehensive series of well-structured governance meetings. We found the structures for maternity services, processes and systems of accountability were not clearly set out. The service had a clinical audit programme in place. However, the auditing of risk was not clear.

The service had displayed in the staff area information from the quality and safety assurance update which provided staff with the maternity dashboard for the specific area. For example, the number of babies born, 1 to 1 care in labour, 3rd and 4th degree tears and post-partum haemorrhage (PPH) cases.

The service did not audit women and birthing peoples records and there was not a clear review of incidents. Incident data showed there were a number of incidents due to poor record keeping and documentation. Incidents showed on more than one occasion, incorrect weights had been recorded for babies and there had been no antenatal recording of fundal height and growth. We also found examples of incidents which were placed as no harm although the information provided showed there would have been harm caused to the woman, birthing person or baby. For example, we saw information which showed a woman attending the birth centre with a baby reported to be large for gestational age. This resulted in a failure to progress and an emergency caesarean section and blood loss.

The situation, background, assessment, and recommendation form for emergency transfers to the main obstetric site was audited by the matron on the birthing centre. We had requested the audit outcomes to review the waiting and

transfer times of women, birthing people and their babies to the obstetric site. However, we were not provided with the information during the inspection or following, in the data received from the trust. During the factual accuracy process, the service provided audit results from 2021 to the time of the inspection which showed a basic level of oversight of waiting and transfer times.

Staff did not follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance and leaders did not always monitor policy review dates. For example, the operational policy for maternity services at the birthing centre review date was May 2019; the standard operating procedure for use of private ambulance to support Maidstone birthing centre, review date March 2021; postpartum haemorrhage guideline, review date May 2021; complementary therapies in midwifery practice guidelines review date November 2022; criteria for giving birth in the birth centre or at home, review date September 2023, and the maternal transfer guideline, review date October 2023. This meant there was a risk staff were not always working to the most up to date guidance.

Management of risk, issues, and performance

Leaders did not use effective systems to manage performance effectively and safely. They did not always identify and act to minimise risks and issues relating to safe care of women and birthing people and babies.

The service did not always participate in relevant national clinical audits. Where audits were completed the outcomes for women and birthing people were not always positive or consistent and managers and staff did not always use the results to improve women and birthing people's outcomes.

Staff we spoke to were not aware of current audits being undertaken within the birth centre and there were no assurances managers shared and fed back to staff from completed audits.

There was a clinical audit programme in place. However, following the recent inspection of the obstetric maternity unit we found the service did not complete audits for Maternity Early Observational Warning scores (MEOWS) or Newborn Early Warning Trigger and Track (NEWTT) but instead had incorporated audit information into the sepsis audit.

Following the inspection, the maternity service told us both MEOWS and NEWTT audits would be added to the audit programme. During our data collection following the birthing centre inspection we did not receive data to show that both had been added to the clinical audit programme or data collection had started.

Senior leaders reported risk was measured through the maternity service dashboard, saving babies lives dashboard and the local maternity and neonatal systems (LMNS) dashboards. Information from the dashboards were reviewed by the maternity board and the monthly executive performance review. We were told the data from the dashboard included key performance indicators (KPI's) and were linked to strategic objectives. However, we found the service could not provide the inspection team with information relating to their KPI's. For example, we were told the service could not provide data for Maidstone Birthing Centre to show the numbers of 3rd and 4th degree tears, post-partum haemorrhages (PPH's) or 1 to 1 care in labour. After the inspection we requested additional data; however, we were informed the data could not be broken down into specific data for the birthing centre.

Leaders did not always identify or escalate relevant risks. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. We found leaders did not always complete risk assessments or make staff aware of the process to follow after identifying risks. For example, the service had identified a risk regarding the lack of an external laundry contract for the collection and washing of double bed linen for the postnatal rooms necessitating the use of an onsite domestic washing machine.

However, there were no guidelines for managing soiled linen. During the factual accuracy process the service told us soiled double duvet covers were disposed of, soiled linen was washed by an external contractor, and staff washed used but not soiled double duvet covers at 90 degrees Celsius. However, they did not provide any evidence to support this, or how leaders maintained oversight, managed and monitored the risk.

There were 8 entries on the service-wide risk register from July 2020 to July 2023. At the time of the inspection the service did not have a separate risk register for the birthing centre.

Managers monitored safe levels of inhalational nitrous oxide (Entonox, or gas and air, for pain relief in labour) and there was an action plan to maintain safe levels at the birthing centre. There was not a current guideline for maternity services on safe levels of Entonox however, this was being drafted at the time of inspection.

There were plans to cope with unexpected events. They had a detailed local business continuity plan. From March 2023 to October 2023 the birthing centre had not had any unit closures.

Information Management

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

The service used a combination of paper and electronic care records which did not reflect national guidelines such as Better Births and from NHS digital.

The service did not always collect reliable data and analyse it. The service did not have a specific dashboard for the birthing centre, instead data was incorporated into the maternity service dashboard. The service told us during the inspection they would add a separate birthing centre dashboard to the maternity services improvement action plan. The service reported to the local maternity and neonatal systems (LMNS) however, the dashboard we reviewed did not show how the service benchmarked against regional and national data for comparison and information we reviewed did not break down statistics by ethnicity.

The information systems were integrated and secure. The service had a digital midwife to support staff accessing electronic information systems. The birthing centre risk register identified there were issues with the electronic record system and the inputting of data. The maternity service was currently working with a national digital group on solutions.

Engagement

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

The service worked alongside the Kent and Medway Local Maternity and Neonatal Services (LMNS) board to improve services for women and birthing people and to deliver NHS England's 'Three-year delivery plan for Maternity and Neonatal services' March 2023. In line with the plan, the decision had been made to change the name of the Maternity Voices Partnership (MVP) to Maternity and Neonatal Voices Partnership (MNVP). The MNVP contributed and worked with the local services and community to contribute to decisions about care in maternity services. The MNVP were focused on

seeking out and hearing from women and birthing people's feedback to develop and improve services through co-production with women, birthing people, and their families. The service was working with the MNVP and LMNS to develop the MNVP service in line with the Clinical Negligence Scheme for Trusts (CNST) and introduce face to face quarterly co production clinics.

The birthing centre facilitated a weekly drop-in breastfeeding café. This enabled women and birthing people an opportunity to gain peer support and guidance on breastfeeding whilst being in a relaxed environment. The café was successful and the service and the MNVP were looking to expand the service.

The service showed us examples of 'Echo', the women's directorate newsletter sent out to staff. The newsletter provided an overview of current work achieved within the directorate and included staff wellbeing information including contact numbers for where staff could access support, action taken in response to information received from staff and professional midwifery advocate (PMA) updates.

Learning, continuous improvement and innovation

Staff told us they were committed to learning and improving services. However, staff did not always have the resources to implement improvements to service and there were delays or lacked evidenced as being implemented.

The service was not always committed to improving services by learning when things went well or not so well. For example, the birthing centre had incidents relating to incorrect weights being taken at birth and incorrect plotting of growth measurements. Staff were encouraged to complete documentation audits for their own learning. However, this was not a formal process and there was no evidence to show staff had received learning or support around the correct plotting and recording of weights.

Quality improvement was routinely discussed at team meetings and within directorate newsletters and senior leaders attended the monthly service quality improvement committee meeting. The service provided information of current projects to improve maternity services and projects were based on issues raised within the quality improvement committee.

The service had a divisional project monthly report which aligned with the 3-year maternity plan. The report focused on the actions within the maternity plan as well as the work being completed alongside current maternity initiatives. For example, Ockenden action plan, Clinical Negligence Schemes for Trusts (CNST) and Saving Babies Lives Version 3.

The service had recently reintroduced antenatal education for women and birthing people. Community matrons were leading on the project and alongside the MNVP, had arranged a service user focus group. Staff had volunteered to be involved in the project and were working with the local maternity and neonatal systems team to potentially use virtual antenatal education modules.

The quality assurance programme was recently re-introduced with the aim to improve the quality of care across women's services in relation to specific topics on a rolling programme of audit.

Areas for improvement

Action the trust MUST take to improve:

Maternity

- The service must ensure women and birthing people are accurately risk assessed for giving birth at the Maidstone Birthing Centre. Regulation 12
- The service must ensure that staff complete mandatory evacuation of the pool skills and drills training. Regulation 12
- The service must ensure all policies and procedures are up to date and in line with best practice. Regulation 17
- The service must ensure the governance processes and information systems fully identify and manage incidents, risks, and performance to reduce the recurrence of incidents and harm. Regulation 17
- The service must ensure it completes regular clinical audits to demonstrate compliance to the Clinical Negligence Scheme for Trusts and Saving Babies lives care bundles. Regulation 17

Action the trust SHOULD take to improve:

- The service should ensure it continues to improve staff compliance to mandatory skills and drills training.
- The service should ensure that all staff involved in planning care are trained at level 3 safeguarding children to reflect national guidelines.
- The service should ensure staff are up to date with maternity mandatory training modules.
- The service should ensure it completes a simulated baby abduction training to ensure baby safety within the unit.
- The service should review incidents related to health inequalities.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 1 midwifery specialist advisor. Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care oversaw the inspection.