King's College Hospital NHS Foundation Trust

Princess Royal University Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Princess Royal University Hospital

Not inspected

We inspected the maternity service at the Princess Royal University Hospital, the rating for the maternity service was requires improvement. We did not rate the overall hospital at this inspection, therefore, the previous rating of requires improvement remains.

Princess Royal University Hospital (PRUH) is part of King's College Hospital NHS Foundation trust. The Trust provides local services primarily for the people living in the London boroughs of Lambeth, Southwark, Bromley and Lewisham.

The PRUH serves a population of approximately 321,000 in the borough of Bromley.

King's College Hospital NHS Foundation Trust employs around 15, 407 whole time equivalent staff with approximately 4,016 staff working at the PRUH.

We carried out an unannounced inspection of the PRUH between 08 & 09 August 2022.

Overall, this hospital requires improvement. We found the maternity services required improvement. Urgent and emergency care, surgery, medical care, critical care, end of life care outpatients and diagnostics and imaging required improvement.

Patients received effective care and they were positive about their interactions with staff. Action needs to be taken to improve the responsiveness and some aspects of the safety and leadership in order to meet the needs of patients.

The previous inspection of maternity services at PRUH was combined with gynaecology services. Therefore, this is the first time we have inspected and rated maternity as a stand-alone core service.

We spoke with 32 members of the maternity team including maternity assistants, junior doctors, registrars, consultant obstetricians and anaesthetists, student midwives, band six and seven midwives, specialist midwives, consultant midwives, safeguarding and perinatal mental leads for maternity, matrons and triumvirate. We reviewed six full sets of women maternity records and prescription charts. We received feedback from three women who had used the maternity service. We reviewed a range of policies, procedures and other documents relating to the running of the service. We observed various handover meetings.

Our inspection Team

The team that inspected the service comprised a CQC lead inspector, one inspector, three specialist advisors and one clinical fellow working for CQC. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out the inspection

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:

- The service provided mandatory training in key skills to all staff but did not always ensure everyone had completed it.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however, not all staff had completed mandatory safeguarding training and not all staff were aware of the baby abduction process.
- The service did not always control infection risks well. Staff did not always follow best practice to protect women, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment did not always follow safety standards. Some equipment safety checks were out of date and daily checks had not always been completed. However, staff managed clinical waste well.
- Staff did not always complete timely risk assessments for each woman and did not always take action to remove or minimise risks to them.
- 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. However, not all information relating to patient care and treatment was documented.
- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times were not always in line with national standards.
- It was easy for people to give feedback and raise concerns about care received, but it was unclear if the Trust was meeting its own target on investigation and shared lessons from complaints.
- Leaders had the skills and abilities to run the service, but they did not always understand and manage the priorities and issues the service faced.
- Leaders and teams used systems to manage performance effectively. They escalated relevant risks and issues and identified actions to reduce their impact. However, not all risks were identified in the first instance.

However:

- 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, and gave bank and agency staff a full induction.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women.

Maternity

- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.
- Staff supported and involved women, families and carers to understand and make decisions about their care and treatment.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

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 but did not always ensure everyone had completed it.

Staff did not always receive and keep up to date with their mandatory training. This was not an improvement from the last inspection. Completion of mandatory and statutory training across all staff groups was just over 85%. In information provided to us post-inspection, it was unclear what the trusts target was for overall compliance with mandatory training. Senior staff told us they had suspended some targets as a result of the Coronavirus pandemic, and it was unclear if any target had been reinstated. However, staff who had not completed their face to face training were booked to attend. A further day was devoted to skills/drills and resuscitation to rehearse emergency procedures.

The practice development midwife oversaw mandatory training. Staff reported that training had improved in the past year. A week's block of mandatory training was now built into workforce planning to ensure all staff completed the full range of training updates on midwifery issues and breastfeeding.

Midwifery and medical staff completed maternal and neonatal resuscitation training, and we saw information showing a completion rate of 91%.

The mandatory training was comprehensive and met the needs of women and staff. Subjects included conflict resolution, equality & diversity, safeguarding adults and children as well as other relevant topics. Most training was delivered by e-learning, although there were some face to face modules.

Maternity

Clinical staff completed practical obstetric multi-professional training (PROMPT) electronic learning as part of their mandatory training programme. The trust sent inspectors a response in regard to staffs compliance with this training, stating they had achieved 90% compliance in 18 months in order to declare compliance acknowledging Covid-19 pressures.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Specialist midwives provided additional training to staff on mental health and cognitive impairment. As at 02 August 2022, 93% of midwives had completed the perinatal mental health training. No data was provided for doctors for the perinatal mental health training.

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

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however, not all staff had completed mandatory safeguarding training and not all staff were aware of the baby abduction process.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Managers and staff showed an understanding of what was important to promote women's safety and to protect unborn and new-born babies. Midwives knew the name of the midwife for safeguarding at the PRUH.

Post inspection, we asked the trust for a target they aimed to achieve for mandatory training in safeguarding, but no figure was provided; therefore, it was unclear if staff were meeting the target.

Figures provided to us showed safeguarding adults level 2 was at 83.70% for all staff, including midwifery and medical staff. Safeguarding children level 2 training was 85.50% across all staff groups and safeguarding level 3 was 70.70% overall completion. The trust told us they had a plan to ensure staff completed all required mandatory training and would keep inspectors updated on progress with this.

The safeguarding team highlighted that safeguarding was everybody's business and staff were aware of guidance on the process to follow when a woman or baby was at risk.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff provided many examples of where they had escalated their safeguarding concerns or made safeguarding referrals to protect women with complex backgrounds. Specialist midwives had also provided effective support to staff when protecting women.

Staff made safeguarding referrals as standard for those young women who were pregnant under the age of 16.

Not all staff were aware of the baby abduction policy and staff were unable to tell us when they last completed a baby abduction drill. We recommended the service consider implementing a process to ensure staff are aware of what to do in a baby abduction situation.

The trust had safeguarding policies, guidelines and pathways in place that guided staff on safe practices. We reviewed the safeguarding policy, which was in date and included relevant national legislation. However, the policy did not include contact details of internal staff and external organisations staff could contact if they had any concerns. There was no escalation flow chart in the safeguarding policy.

Maternity

Cleanliness, infection control and hygiene

The service did not always control infection risks well. Staff did not always adhere to control measures to protect women, themselves and others from infection.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and uncluttered. Most furniture was wipe clean and conformed to infection prevention and control best practice, however, two mattresses had rips and tears in them and did not conform to infection prevention control (IPC) standards. Inspectors highlighted these to staff and they were removed and new mattresses placed on order.

Sinks in clinical areas had elbow operated taps to reduce the risk of contamination.

In the ward areas, including the triage and induction suite, we saw single use curtains were used. These were regularly changed.

The service generally performed well for cleanliness; however not all areas were audited. Data from the trust reported that hand hygiene audits were completed every month but there remained gaps in the completion and it was not always clear where in the unit the audit had been completed and whom by. Following the inspection, the trust told us 157 audits were undertaken between January and June 2022 with an average 97% completion rate. The trust also told us that all areas were now audited.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

From July 2021 to June 2022, staff achieved an overall 97% in the hand hygiene audit across the maternity inpatient service.

For the period of July 2021 to June 2022, there was one case of community acquired MRSA (antibiotic resistant bacteria) and one case of hospital acquired Clostridium difficile. There were seven E. coli cases reported for the Women's Health Care Group for June 2021 to June 2022.

Staff followed infection control principles on the use of personal protective equipment (PPE). The maternity service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. From January 2022 to June 2022, staff achieved an overall 92% in the PPE audit and using a red amber, green (RAG) rating system, the trust was rated as amber in January, March and April 2022.

Women who were booked for elective caesarean section (c-section) were screened for MRSA during their pre-operative assessment appointment. The women's record we reviewed confirmed that MRSA screening was completed when indicated.

Not all staff followed infection control principles, as inspectors observed staff wearing jewellery on their hands as well as senior staff working in the ward areas who were not observing bare below the elbows practice.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff carried out the decontamination of surgical instruments in accordance with national guidance.

Maternity

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date and daily checks were not always completed. However, staff managed clinical waste well.

Call bells were available in every patient bathroom. There was a mixture of ligature free call bells in some bathrooms but non-ligature free in others. We highlighted four call bells in patient bathrooms which were not ligature free, to senior management. We were told these would be replaced, within a few days, with ligature free call bells. Post-inspection, the trust supplied evidence of these changes having been made.

The design of the environment followed national guidance.

Staff carried out safety checks of specialist equipment. However, in the six pieces of equipment we reviewed, including resuscitaires and resuscitation equipment, there were gaps in the daily check sheet accompanying them, in all six. Some of the equipment had gaps where no daily checks had been completed for four days in a row. Other equipment had gaps which highlighted a sporadic check had taken place.

Some equipment throughout the maternity department were out of date. For example, we found 12 single use items which were stocked but had past their use by date. We gave these items to staff to replace.

The service had suitable facilities to meet the needs of women's families including a dedicated bereavement suite.

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

Staff disposed of clinical waste safely and followed the correct colour-coded systems.

The labour suite and the wards required any visitors to be let in and out to maintain security. Security personnel were placed at both entrances to the maternity department. Staff told us security staff provided 24/7 cover and had been in post since the day before our inspection. This was in response to our findings at the trust's other hospital site.

Assessing and responding to patient risk

Staff did not always complete timely risk assessments for each woman and did not always take action to remove or minimise risks.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. We noted observations of women's well-being were not always carried out in a timely manner. In two records we reviewed it was noted observations should be taken every hour; however, we noticed the records were sporadic and not taken or recorded every hour in line with the medical instructions. When staff checked women's' vital signs as required, these were inputted into an electronic system which automatically calculated the Modified Early Obstetric Warning Score (MEOWS). This was then automatically escalated according to the level of concern. Staff told us they would also verbally escalate any concerns to relevant staff members (midwife in charge or medical staff). The score also dictated how often women should be re-monitored to identify or prevent deterioration.

The maternity service also used the newborn early warning trigger and track tool (NEWTT) to identify babies and women at risk of deterioration. However, the Birmingham Symptom-specific Obstetric Triage System (*BSOTS*) was not used in triage. Staff told us this have not properly been rolled out in the maternity service and was still in the pipeline. However,

post inspection the trust told us BSOTS was being used in triage at the time of inspection, although we did not see evidence of this, nor were staff aware. This safety risk was escalated to senior managers and information received post inspection showed that an urgent review of the current triage policy has been undertaken to ensure the early identification of deteriorating of babies. The trust told us BSOTS will be implemented in the service by autumn 2022.

Each midwife was responsible for several women, which included taking their observations. This task was often delegated to Midwifery Support Workers (MSW's). If the MSW's had any concerns regarding the women's observations, they would escalate this to a midwife. All MSW's we spoke with told us they felt they had been trained appropriately for their role.

Staff described how they would respond to a medical emergency. This was in line with the trust policy. Staff undertook scenario training on a yearly basis. This included midwives, midwife support workers, obstetricians and anaesthetists.

Staff we spoke with and observed were familiar with signs and symptoms of sepsis. Staff used the sepsis bundle when required. In all records we checked; staff completed risk assessments for venous thromboembolism (VTE). The Women Health care group score card for the period of July 2021 to June 2022 showed the care group met its target for VTE risk assessment and care of IV lines. Although, there was poor documentation on the recording of the care of the IV lines, with a completion rate of 70% against a trust target of 95%.

Not all women had a carbon monoxide screening. Out of six records we reviewed, every record was missing carbon monoxide results, which should be taken at initial booking and again at 36 weeks gestation, in line with trust policy. Four records showed carbon monoxide readings were taken at initial booking but not at 36 weeks gestation, and the remaining two records showed the recording being taken at 36 weeks gestation but not at initial booking.

The service had enough suitable equipment to help them to safely care for women and babies. Each room within labour suite had their own CTG (cardiotocography) machine, a resuscitaire and equipment to monitor women for deterioration.

Shift changes and handovers included all necessary key information to keep women and babies safe.

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, and gave bank and agency staff a full induction.

The service had enough nursing, midwifery and medical staff to keep women and babies safe.

Managers accurately calculated and reviewed the number and grade of midwives, MSW's and support staff needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of women, and the number of midwives and healthcare assistants matched the planned numbers.

The service had a vacancy rate of 11.61% in June 2022, this was an increase from May 2022 when the vacancy rate was 9.91%. Following the inspection, the trust provided updated figures which showed the vacancy rate for Midwifery staff at the PRUH in June 2022 was 4.4% for qualified staff and 4.5% unqualified.

Maternity

The service had a turnover rate of 13.62% in June 2022, this was an increase from May 2022 when the turnover rate was 12.73%.

The service had a sickness rate of 5.31% in June 2022, this was similar to May 2022 when the sickness rate was 5.35%.

The service filled 637 shifts with agency or bank staff in June 2022.

Managers told us bank and agency staff booked shifts regularly and were familiar with the service.

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number.

Consultants carried out a daily ward round on the clinical areas.

There were three midwives on call each day in addition to the daytime shift to cover home birth and the birth centre. Rotation of community midwives through the birth centre was a safe model for maintaining competencies. Following our inspection, the trust told us the current workforce comprises 3 midwives, an MSW and a band 7 midwife from Monday to Sunday 9am to 5pm.

Staff were positive about working in the maternity unit. Managers told us that if a member of staff was off, even at short notice, they would be able to get bank or agency staff who had worked on the unit before. All staff were expected to have a break during their shift. Their allocated time was written on a white board and the ward manager and matron provided cover to make sure the breaks were taken.

Information provided by the trust indicated two midwives and one MSW covered the Maternity Assessment Unit (MAU) 24 hours per day, seven days a week. In addition to this, one additional band 7 midwife supported between 9am and 5pm, seven days a week.

The trust used the Birthrate plus acuity app which has been in place since January 2021. This records any red flags or areas of concern within the staffing data capture. Birthrate plus provides a 12-month report on this data, which is more detailed than the trust can produce itself. Red flags were raised in real time for action and escalated to the matron in and out of hours, to the labour ward coordinator and manager on call dependant on the action required. Morning and afternoon huddles identified red flags and document the recommendations in response to these. In documents sent to inspectors, post-inspection, there were clear recommendations on days where staffing was short, for example, we could see recommendations to move staff from other areas or to bring in management staff to support clinical practice.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, not all information relating to patient care and treatment was documented.

Some information was only kept within electronic records which meant staff had to log into the electronic system to review information as well as reviewing paper notes.

Maternity

We identified concerns within documentation standards of the triage assessment records. We identified that staff had failed to document the timings within several women's notes of when they arrived and when they had been triaged. There was also a failure to document the triage category women were assigned, which identified the actions required in terms of any escalation. Following the inspection, the trust told us that records are electronic apart from intrapartum notes and risk assessments are completed electronically.

Records were stored securely. Paper records were stored in filing cabinets at the midwives' station. These were kept closed when not in use.

We reviewed eight sets of completed records. Women's notes were mostly comprehensive, and staff could access them easily, but not all note entries were timed, and risk re-assessments were not always documented. Risk assessments for mental health and overall pregnancy assessment were completed at booking but not always completed at 36 weeks, in four of the eight records. Four of the records showed no evidence of a domestic abuse assessment. In the records reviewed there was no evidence of female genital mutilation (FGM) assessment. However, staff showed and told us the booking questionnaire included FGM assessment. This was a mandatory question meaning all women would have to asked if they had received FGM before the booking could be completed electronically.

Following our inspection, the trust told us domestic abuse assessments were completed on the online software programme used for patient records and is a mandatory field. These assessments are recorded on 3 separate occasions during a pregnancy and this field cannot be left uncompleted.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. A pharmacist was allocated to the wards and attended throughout the week to give support. They audited the medicine storage and were able to provide support with ordering additional medicines as required. Out of hours pharmacist support was available if required. A pharmacy technician role had been allocated to the wards. They organised the prescribed medicines which women take home with them to minimise discharge delays. Staff also explained to women how they should administer their medicines.

There was no audit of medicines taken off site by community midwives. This was raised with the trust after inspection. The trust told us a medicines and safety audit would be carried out in all maternity areas including audit on medication taken by community midwives.

Staff recorded allergies including medicine allergies in patient records.

Staff completed medicines records accurately and kept them up to date. We reviewed six prescription charts for women on the wards and found that these were, in the main, accurate and up to date. All prescriptions were signed and dated with legible writing used throughout.

Staff stored and managed all medicines and prescribing documents safely. A sample check of routine medicines and IV fluids showed these were in date, labelled and placed in a way that avoided confusion or would potentially allow medicine to be mistaken for a similar one.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Pharmacists checked and reviewed women's' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the trust incident reporting policy. Staff told us they received updates about errors or incidents. Staff were able to explain about some recent medicine incidents and the learning that had been undertaken.

Medicines required in an emergency were available. They had a tamper evident seal to ensure they were safe. Staff were required to record weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency, however, in all checks we reviewed there were sporadic gaps and daily checks had not always taken place.

Emergency drugs were tamperproof and in date.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported most incidents and near misses in line with trust/provider policy. All staff we spoke with, spoke confidently around the incident reporting policy and what incidents should be reported. However, in information provided to inspectors, post inspection, the trust had rated themselves as 'red' for 'evidence of change in practice arising from serious incident investigation'. On a red, amber, green (RAG) score, red indicates 'worse than expected' for compliance.

The trust also had seven pending investigations being undertaken by an external organisation into several maternity incidents.

The service had recorded five never events within the service. These related to retained swabs, with the first reported never event recorded in 2016 and the most recent in March 2022. Staff we spoke with told us there had been learning from these events, including an update to a swab safety checklist. Senior managers we spoke with told us they were working on a plan to increase awareness amongst staff, talking about swab safety, in addition to implementing a weekly audit of swab compliance and simulation training for retained swab recognition.

Managers shared learning about 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 if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any serious incident. For example, we saw evidence of learning sessions, including the development of newsletters and learning aids, relating to cord prolapse and the associated risks. Staff we spoke with were able to provide details of learning they had received and felt refresher sessions were a good way of keeping up to date on relevant topics.

All still births and neonatal deaths were investigated and reported to the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) in line with the national guidance. From January to May 2022, the service reported four neonatal deaths in the service. MBBRACE launched the perinatal mortality review tool kit (PMRT) and the

service used this tool to review perinatal mortality. MDT staff reviewed and discussed patient deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites. Examples of change in practice following learning from death include enhanced bereavement training for neonatal staff around care after death and three MDT training sessions on care after death delivered by Pan London lead nurse for complex and bereavement care of staff.

Is the service effective?

Good

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies relating to the maternity services and found these were all up-to date and reflected national guidance. There was evidence the trust had used green-top guidelines in the development of policies. Green-top guidelines are national recommendations which assist clinicians and patients, developed by the Royal College of Obstetricians and Gynaecologists.

Staff told us despite having policies to enable them to deliver high quality care to women and their babies, there was still variation with medical staffs decision making, which led to variations in practice. An example of this was identified whilst staff worked in the antenatal care unit, who told inspectors that discharge from the unit appeared to depend on criteria set by each individual medical staff and their experience level. It was unclear if the unit management team had any plans to rectify this issue.

We saw examples of maternity audits that had been carried out across the trust, for example induction of labour, pre-term birth and major obstetric haemorrhage audits were undertaken. Action plans were then developed where area for improvement had been identified. It was unclear if sustained improvements had been made as some audits had only just been resumed following the Coronavirus pandemic.

There were also hospital-specific regular audits on infection prevention and control, medicines and records amongst many others. Results of audits were reported at maternity ward meetings, and actions identified.

Screening in the first trimester included an offer of combined screening for chromosomal abnormalities and pregnancy associated plasma protein A (PAPPA), an indicator of risk of some abnormalities and risks to the mother and baby. Only women meeting specific risk criteria had 12- week ultrasound scans with Doppler to measure blood flow between the placenta and the foetus.

Following the inspection, the trust told us all women were screened in the first trimester for preeclampsia in accordance with the fetal medicine foundation protocol and this was subsequently repeated in the second and third trimester.

The service had an audit meeting schedule calendar which was reviewed at monthly audit meetings. We saw that the trust generally held regular monthly audit meetings except December 2021, January 2021, April 2022 and August 2022 where the meetings were cancelled due to staff sickness.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. We observed multidisciplinary handover meetings and found staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Where appropriate, staff would refer or signpost women for further support. The service also had specialist midwives to cover a variety of holistic needs who would also be involved with a woman's care if required.

Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff and women using the service were all complementary about the food which was available. The service could meet the needs of all dietary requirements and cultural or religious requirements. In addition to this, staff provided additional provisions, such as tea and toast in between set mealtimes when women required this.

Staff fully and accurately completed women's fluid and nutrition charts where needed. These records were stored on the electronic observation recording tool. We did not observe any woman requiring this type of observation during our inspection.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for women who needed it. However, this was not a common requirement within the service.

There was a specialist team in place to manage women with gestational or long-standing diabetes. The team told us they were well supported and had enough resources to deliver safe and effective care.

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women we spoke with all confirmed their pain had been well managed. We observed audit results taken across the maternity department which demonstrated there had been improvements made to the provision of pain relief intra-operatively and post operatively. Pain relief such as Nitrous Oxide (gas & air), epidural and oral pain relief was available.

Staff told us there were no problems in obtaining pain relief or other medication for women. All the women we spoke with told us they had received pain relief as required.

Maternity

Patient outcomes

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

A centrally produced obstetrics dashboard reported on activity and clinical outcomes for the maternity department. The obstetrics dashboard for the previous 12 months showed the target of booking 90% of women by 12 weeks and six-days was not yet being met. The number of late bookings over 20 weeks was also over target. We were told the Clinical Commissioning Group had been working with pharmacies and GPs to advertise the importance of early booking.

Following the inspection, the trust told us they are aware of the low compliance for screening by 10+0 weeks; this is on the trust risk register as a high risk with an action plan to address this and to mitigate the risk. In subsequent months the compliance for booking by 10+0 weeks has increased to 45.8% in October, 60% so far in November 22 (thus increasing compliance with screening results available by 10 +0 weeks).

The service participated in relevant clinical audits such as the measurement of Symphysis Fundal height (SFH). This audit showed a need to remind obstetricians to take SFH in clinic. Other audits were completed such as the timeliness of antenatal screening, which the trust scored 37.8% performance. This was below a nationally acceptable threshold of greater than 50%. Apart from the need to remind obstetricians to take SFH in clinic, it was unclear what else the trust was doing to improve this. It was also unclear if the trust had developed a comprehensive plan to measure improvements, no information was supplied during or post-inspection and several midwives we spoke to, were not able to articulate any plans for improvement.

An audit for avoidable repeat tests showed trust performance at 2.7% which was above the acceptable threshold of 2.0%.

Other audits, such as the timely assessment of women with hepatitis B and foetal anomaly ultrasound achieved 100% compliance against national targets.

The hospital participated in the MBBRACE 2021 audit. The result showed the still birth rate was 3.17 (per 1000 live births) which was slightly higher than the England average. The hospital had an action plan in place to improve outcomes. This included quality improvement projects, introduction of foetal wellbeing midwife across site, increase training in foetal monitoring and virtual practical obstetric multiprofessional training (PROMPT) and SIMS training.

The trust participated in the 2021 National Maternity Dashboard audit; the result showed the trust performed similar or better than expected on most indicators audited. The trust performed better than national average on eight indicators, this include babies born preterm, women with vaginal birth following caesarean-section (c-section), babies with first feed of breast milk, skin to skin contact, women who were current smokers at delivery, women with 3rd or 4th degree tear at delivery, women who had a PPH more than 1500ml. The trust performed similar to national average on women who were current smokers at booking.

An audit of abnormal antenatal cardiotocography (CTG) audit in 2021 showed the service did not always meeting national and clinical guidelines. The RCOG and NICE guidelines (2011, amended 2021) advised an emergency caesarean birth should be carried out as soon as possible within 30 minutes of decision making for category 1 (immediate threat to the life of the woman or foetus) and within 75minutes for category 2 (maternal or foetal compromise that is not

immediately life threatening). The audit result showed caesarean birth were carried out for Cat 1 between 15 minutes to 43 minutes and 28 mins to 295 mins for Cat 2. Although the result showed an improvement on staff documentation and compliance with category 1 and category 2 of emergency caesarean section. However, the service did not always meet the national and clinical guidelines.

Managers and staff carried out a programme of repeated audits to check improvement over time. It was clear from documents provided post-inspection, the trust had a plan to ensure audits which were not achieving compliance, were set against specific objectives to ensure compliance was achieved. This included learning sessions for staff.

There were 11 intrapartum transfers in total in the time period. (9 transfers from PRUH to King's College Hospital, 2 transfers from DH to PRUH) between August 2021 to July 2022.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work, and supported staff to develop through yearly, constructive appraisals of their work. The clinical educators supported the learning and development needs of staff. Staff had undergone clinical supervision sessions as part of their yearly appraisal. Any improvements or learning required from this were documented in the staff members appraisal document. We saw evidence of four staff appraisals which highlighted areas for additional learning.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw minutes from meetings were comprehensive and detailed, noting the actions and recommendations listed at the end of the meeting minutes.

Some staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role such as CTG monitoring and mental health awareness.

To ensure staff were not left without vital updates, information was shared with staff through other communication methods including private social media groups, emails and newsletters.

Managers identified poor staff performance promptly and supported staff to improve. There were clear processes for staff to follow when staff were identified as underperforming. Senior leaders discussed examples of where they were managing challenging behaviour. Medical leaders also had oversight of the locum medical staff who worked within the service to ensure they met the expected standards.

Multidisciplinary working

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

Maternity

We observed all staff working well as a team to ensure women had safe care and treatment. Staff were complimentary about other members of the multidisciplinary team (MDT). The service had introduced daily consultant led ward rounds within the labour suite, which had improved the formulation of plans for women in this area. There were also huddles held in other areas to update staff on plans for women and their babies.

A multidisciplinary meeting was held every week for staff from the PRUH to review maternity cases at the hospital.

We were told that there were regular communications with local GPs as well as social services. However, we did not see any evidence of these communications documented. The trust told us GP and social services communication was completed via the software programme used for patient records. Documents are scanned onto the electronic system which GP's and social services have access too.

Seven-day services

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

All women could report to the hospital in an emergency through the accident and emergency (A&E) department.

The maternity unit had ultrasound scanners available that could be used out of hours if necessary, and we observed an instance of this taking place with a chaperone.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was also access to an advice line, triage assessment and the maternity assessment unit.

The service held regular health promotion classes and workshops to support women and their loved ones. This include **i**nfant feeding support classes, antenatal classes and births after c-section workshops.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service had relevant information promoting healthy lifestyles and support on every ward. Staff gave health promotion advice to women on various topics which was evident on patients record reviewed. This included gestational diabetes, alcohol, smoking cessation, immunisation, flu vaccines, Covid vaccines, breastfeeding, safer sleep, healthy eating, vitamin D, sudden infant death syndrome (SIDS) and emotional wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Maternity

Staff told us they made sure women consented to treatment based on all the information available. However, of six records reviewed, two did not record any type of consent. Senior staff told us these women had given verbal consent but staff had not yet documented this at the time of our checking.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust provided data which showed midwives had an overall compliance of 93% in perinatal mental health training. No other data was supplied by the trust for other staff groups.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were aware of the Gillick competencies and Fraser guidelines relating to the assessment of maturity regarding decision making for children under the age of 16. However, staff said it was rare for these competencies to be used.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. We saw staff take time to interact with women and those close to them in a respectful and considerate way. Women said staff treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Most patients and relatives told us they felt respected by staff and they were very caring towards them. Where women were known to have additional and complex needs staff appeared to be considerate of this and treated all women with kindness

Maternity

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

From July 2021 to June 2022, the hospital's maternity Friends and Family Test showed an average response rate of 19.5%, this was better than the trust target of 18%. The maternity service performance was 88.5%, which was lower (worse) than the trust target of against 94%. The maternity only achieved the trust target in September 2021, rated amber in seven months and rated red in four months. Following the inspection, the trust told us they did not recognise these response figures and told us they consistently achieved above 90% from November 2021 – October 2022. However, no documentation was provided to evidence these figures.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. During our inspection, we witnessed a distressed women being comforted and supported by staff. This person was taken to a private area away from other patients, to minimise the distress.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We heard from staff on how they had coped in situations where bad news had to be delivered. Staff told us they generally felt well supported and had been given training on this subject.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Midwives involved the support of specialist midwives where additional support was required. For women and those close to them who required support following the loss of a baby, the bereavement midwife provided support to them in a designated bereavement suite.

Women who had known mental ill health had further support from the specialist midwife for mental health. In addition to this, ongoing care and support could be requested if this was required.

Staff told us they were also able to request support from faith leaders for women who required support. Staff told us they had access to a range of faith leaders. Staff had also had support from them when they had experienced a challenging and emotional situation.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand and make decisions about their care and treatment. However, the trust was recognised as one of the worst performing in the country for CQC's maternity survey.

During our visit we observed staff making sure women and those close to them understood their care and treatment. Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

Maternity

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We spoke with four women who told us they felt empowered to give feedback to staff, if or when, it might be required.

The service encouraged the women who used the service to engage with other organisations such as the maternity voices partnership (MVP). We spoke with the local MVP service who told us they were working to strengthen the relationship with the trust. The trust also told us they were supporting women to speak with the MVP service, however, four women we spoke with during the inspection were not aware of the MVP.

Staff supported women to make advanced and informed decisions about their care. Staff supported women to make decisions about their pregnancy during antenatal appointments and recorded this within their records. Specialist midwives were also involved with some women to enable them to make informed decisions about their care and treatment.

The trust was highlighted as one of eight 'worse than expected' trusts in England, in the CQC maternity survey for women who gave birth between 1 and 28 February 2021. As a result of these results, CQC asked for an action plan on how areas of concern will be addressed by the trust. We will continue to monitor progress through our continuing monitoring and engagement activity. During our interview of senior staff within the service, it was not clear what actions had been taken to immediately address the issues highlighted in the survey results. Staff told us they were still seeking to understand the results as they did not always recognise the concerns highlighted.

Is the service responsive?

Requires Improvement

We rated it as requires improvement.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered. The service provided a patient telephone line which 24-hour, 7 day a week access for patients to speak with a trained midwife about any concerns they may have. Pregnant women beyond 14 weeks were asked to attend Maternity triage if they had concerns. The trust told us all women were provided with an email address for their community midwifery team for contact.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems, learning disabilities and dementia.

The birth unit had capacity to care for women who were expected to have low-risk births and there were opportunities for women to find out about birth options early in pregnancy.

The signage to the Oasis Birth Centre and the delivery suite were clear. At night the main reception was open until 10pm. After that, women needing access to the labour ward were admitted to the hospital building through an intercom system.

Managers monitored and took action to minimise missed appointments and ensured that women who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

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

Staff made sure women living with mental health problems and learning disabilities, received the necessary care to meet all their needs. Staff supported women living with learning disabilities by using 'This is me' documents and information passports where applicable. Staff ensured any additional needs, which were required when the woman was admitted, was part of their plan of care. All women with complex needs would have the specialist midwife involved in their care.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

The service had information leaflets available in languages spoken by the women and local communities. During our inspection, we mainly observed information in English, however staff assured us this could be provided in a range of alternative languages, font and braille if this was required.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff spoke positively regarding a relatively new implementation of using a face-to-face interpreter through a portable interactive screen. Staff told us women found this to much better than telephone interpretation services.

Wards were designed to meet the needs of women living with disabilities. The maternity service had wheelchair access to the wards, accessible toilets and showers which were suitable for people with reduced mobility. The wards had designated rooms that was spacious and adapted to use for women with disability. The maternity services had birthing balls, birthing pools and stool to promote comfort of women in labour.

Women were given a choice of food and drink to meet their cultural and religious preferences. Four women we spoke with told us they were supported in their choices, only being advised differently if it was medically indicated. For example, one women told us they did not initially want a C-Section but staff gave them information which suggested the birth of their child would be safer if a C-Section was performed. This lady did not feel pressured into this decision but felt well supported to make their own decision with their family.

We spoke with 2 women who told us they were supported in their decision-making regarding all aspects of their delivery. They told us they were supported in their choices for different methods of birthing, such as using the birthing pool or the risks and benefits of a C-Section. Both patients told us they had discussed with staff the pro's and con's of different pain relief and given enough support to encourage breast feeding.

Women we spoke with told us they had been offered a birthing pool for deliver of their baby. However, due to the unit being busy, one woman was unable to use the birthing pool as there were none available at the time of their delivery.

Maternity

Access and flow

People could not always access the service when they needed it and did not receive the right care promptly. Waiting times were not always in line with national standards.

There were 1,883 births at this location between January and March 2022. Of these 1,179 were classified as unassisted (normal) delivery, 686 were assisted deliveries and 18 home births. The trust told us women who gave birth outside of an intrapartum area or at home and this was unplanned, it would be incident reported and investigated on an individual basis. No themes or trends were identified through any of these investigations.

Post-inspection, the trust provided us with an audit of waiting times for women to be seen in the triage area. In a 24-hour period in June 2022, 19 women were seen within this timeframe, and an 84% compliance rate was recorded for women who were seen in accordance with Birmingham Symptom-specific Obstetric Triage System (BSOTS) recommendation of wait times. In July 2022, this compliance rate had reduced to 69% of women being seen within BSOTS recommendation. According to the audit sent by the trust, limitations were recorded as; not all attendance to triage was fully documented and therefore unable to be audited, staffing issues contributed to the reduced compliance rate and delays in obstetric review and/or lack of escalation by midwifery staff. We raised our concerns about the triage service and their responsiveness to women's needs with the senior leadership team who told us they would look into this and form an action plan to rectify this issue. We have asked the trust to keep us informed of their progress with this through our engagement.

Staff told us women within the triage assessment unit were delayed at times due to accessing medical advice from more senior obstetricians. However, staff we spoke with, including senior management, were unable to tell us of any plans to improve this. Following the inspection, the trust told us a dedicated medical rota supporting MAU and triage was implemented from May 2022 covering the hours 0800-1700. Out of hours support is provided by an on-call team. No evidence of this was provided at the time of the inspection or post-inspection.

The trust had a target of 50% of women being booked for an antenatal appointment within 10 weeks. Out of a 12-month period, the trust achieved compliance for three consecutive months (June 2021-August 2021), outside of these months, the trust did not achieve the target rate. Some months (April 2022 and May 2022) achieved a compliance rate of 23.8% and 22.8%.

In the same period, for bookings before 12 weeks + six-days, the trust had a target of 90%. In a 12-month period, the trust did not achieve compliance. The lowest compliance rate was 74.7% in January 2022.

Managers and staff started planning each woman's discharge as early as possible. On the ward, staff tried to ensure the discharge process ran smoothly for women. Consultant led ward rounds were conducted early to enable the service to have an overview of how many discharges were likely that day. This information would then be discussed during an MDT meeting held each day.

Staff in the community had raised concerns over the cancellation of the home birth service over the last few months. This had mainly been in relation to staffing issues (either in the community or in the hospital which required community staff to help with). Information supplied by the trust did not make clear how many women gave birth in hospital due to the cancellation of the home birth service.

The service moved women only when there was a clear medical reason or in their best interest. Staff tried not to move women between wards at night, however if women were ready to move to the postnatal ward, and a labouring woman required a room in the labour suite, the needs of the labouring woman would come first.

Maternity

From August 2021 to July 2022, there were 11 intrapartum transfers between the maternity service based at Kings College Hospital and the Princess Royal University Hospital maternity service.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs.

Staff told us; any woman who had complex needs would have detailed discharge plans created with relevant specialist midwife input. Examples were discussed where staff had completed some detailed plans and involved external agencies to ensure women and their babies were safe on discharge. One example also included how they managed to ensure existing children were cared for whilst their mother was admitted to hospital to give birth

Staff supported women and babies when they were referred or transferred between services. When women were referred into the acute setting by community colleagues, women were supported by the community staff.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. However, it was unclear if the trust was meeting its own target on investigation and shared lessons from complaints.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service displayed complaints information and how to raise concerns in all patient areas. Four women we spoke with were aware of the Patient Advice and Liaison Service (PALS) and how to contact them if they had concerns.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

It was unclear from trust data, how many complaints had been received into the maternity service within the previous 12-month period, despite asking the trust for this information. However, in documentation provided by the trust, we were able to review 32 complaints, none of which were dated. Complaint descriptions were noted and inspectors were able to see the nature of the complaint. There were a number of complaints relating to the perception of rushed appointments by staff, lack or poor communication, delays in test results and a complaint regarding an overcrowding of an area where a woman was undergoing sensitive and personal treatment. It was unclear from speaking to senior leaders, during the inspection, and in any documentation provided by the trust, post inspection, what themes, trends, actions and changes had been implemented as a result of patient complaints.

Managers did not always share feedback from complaints with staff which meant there was limited learning. Staff were unable to give examples of how they used women's feedback to improve daily practice. Interviews with senior managers during the inspection showed this was an area of concern which had been identified.

Complaints had been managed in a different way due to staff depletion. Staff were unable to share with us any examples of feedback received as a result of a complaint or any examples where learning had been identified from any complaints.

Is the service well-led?

Good

Maternity

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. However, they did not always understand and manage the priorities and issues the service faced.

The maternity service was managed as one Care Group across two sites and the care group reported to the Hospital Executive team. The trust maternity triumvirate included the director of midwifery, clinical director and general manager. The trust triumvirate were supported by the hospital head of midwifery, service manager and deputy clinical directors.

The trust Chief Nurse was the Executive Director of Midwifery and had regular meetings with the Director of Midwifery.

The women's care group had a clearly defined accountability structure. Department and service managers were visible and matrons were open with staff. Work had been done to build relations between hospital-based midwives and community midwives, including joint training to help develop shared leadership with women.

Community midwives considered they were well managed and supported. We saw evidence of good risk reporting and responsiveness to complaints to avoid repeats of unsatisfactory occurrences. Teams met monthly to a schedule planned a year ahead, to share information. The meetings were minuted.

The director of midwifery (DOM) was a strategic role and was supported by a head of midwifery (HOM) who would usually take ownership of the operational aspects.

Senior leaders told us there were safety champions in place. Most staff were unaware of who the champions were. Information we reviewed after the inspection showed a new non-executive director of maternity safety champion had been appointed. The service had safety champion representation from all relevant areas (neonatal, anaesthetics, obstetrics, midwifery, board and non-executive) and met on a monthly basis. The executive safety champion conducted regular walkarounds with the last one being described as 'positive' with staff being able to recall improvements which had been made.

Staff all commented on the visibility of the DOM and felt they were sighted on the challenges faced on a day to day basis. There was also recognition by most staff that the increase in matrons had improved the support staff received.

Despite positive changes being made in some areas since our last inspection; the pace of overall change did not support safe care. One area which was highlighted as a concern was the triage assessment unit. There had been minimal evidence of any drive for improvement within this area. We raised this with the senior leadership team who acknowledged this was an area of concern which had not been prioritised appropriately. We were also concerned about the boards oversight over the pace and scope of change within the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The trust women's care group aimed to support women and birthing people throughout their lives. They strived to be 'a world leading service providing safe, evidence based, kind and personalised care to all women, birthing people and their families by a valued team that are highly skilled and educated'.

Maternity

The trust had a Women's Health Strategy in place which encompassed both King's College Hospital Hill and PRUH. The strategy was labelled as 2022-2024. The strategy had a focus to strive to be a world leading service providing safe, evidence based, kind and personalised care to all women, birthing people and their families by a valued team that are highly skilled and educated. As part of the consultation phase of the strategy, 185 questionnaire responses were returned from women via a number of patient and public involvement organisations such as Maternity Voices Partnership (MVP) and Health Watch.

Staff we spoke with told us they had been provided opportunity to contribute to the strategy and given time to read it. The strategy contained a 'staff voices' section which highlighted staffs contribution to the strategy. One key theme identified from this section was staff highlighting staffing vacancies as a barrier to the delivery of world-class care.

Maternity staff understood the hospital's role in the wider south-east London strategy to place women at the centre of maternity care, to improve equity of access, continuity of care and meet maternity quality standards. Managers recognised there was still work to do as new staff appointments were made.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff acknowledged that senior leaders and the trust executives had taken positive steps to improve the culture within the service. Senior leaders were aware the cultural change would take longer to improve but they had a focus on well-being of staff. Senior leaders recognised many staff had been negatively affected by the changes and pressures resulting from the Coronavirus Pandemic.

Although morale was positive on the clinical front, it was affected by non-clinical issues such as the frustrations of the limited compatibility between different computer systems and the difficulties obtaining women's notes, which affected most areas of the hospital, these were the same findings in our previous inspection. Staff also felt frustrated by the lack of environmental space or good use of the space which was available. These was recognised and high on the corporate risk register.

New members of staff on the maternity ward said that they were made welcome and everyone was willing to help out.

Staff were aware of the Freedom to Speak Up Guardians (FTSUG) in the trust and had started to use them regularly to escalate their concerns.

Community staff we spoke with felt relationships between them and hospital staff were better than they had been previously. There were mixed comments from community staff regarding how welcome they felt when they worked in a hospital setting. Some community midwives felt the hospital staff were supportive and others felt there was room for improving relations. Several staff suggested they would like more social events between community and hospital-based staff to build upon relationships.

Governance

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

Maternity

The maternity service sought reassurance through various governance meetings in the service, cross-site meetings, HSIB action tracker meeting, care group meetings and trust board meetings. This included quality review meetings, weekly risk meetings, patient safety meeting, senior team meeting, triumvirate meeting, and women's health board, maternity quality governance meetings and maternity quality governance committee.

Management meetings took place across the site by teleconference to reduce travel. Doctors and midwives said these worked well.

The service had effective systems for identifying risks and planning to eliminate or reduce them. A local risk register was in place and we saw evidence of discussion about workforce issues and future planning at local and trust level meetings.

Staff facilitated robust, well-structured handovers using recognised tools. This approach demonstrated information shared about women with colleagues was discussed, documented and used appropriately to keep people safe.

Staff were provided with a services dashboard, which was reviewed as part of the women's quality and risk meetings that took place monthly. The meeting minutes for these demonstrated good multidisciplinary team attendance where the dashboard, audits, risk register and incidents were reviewed. Staff who attended used an action log to review completion and progress of allocated actions.

We reviewed triage related red flags, for example delays relating to staffing and red aspects on the maternity dashboards (where targets had not been met and/or where we saw no improvement). We could see the trust were monitoring these areas of concern but there appeared to be a lack of pace to take significant steps to ensure improvements.

Meetings were chaired by the most appropriate person, with clinical leads or executive leads attending as necessary. We saw a selection of meeting minutes and found them to be detailed and clear. Meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Meetings operated across both sites and fed into the trust executive board. Service leads confirmed that they met with the board regularly to discuss performance.

In response to a national maternity safety report, the trust had carried out a cross site gap analysis on the maternity services and developed an action tracker to monitor their actions. The trust had benchmarked themselves against 89 actions that the trusts was responsible for. We saw the trust had RAG rated themselves as green on 33 actions, amber on 51 actions and red on five actions. Actions that the trust rated themselves as red included management of complaints by the maternity team, seven days a week bereavement support provision and change in practice arising from SI investigation seen within six months of investigation. Staff were unfamiliar with this report and told us they had not been included in the planning, nor told of the action plans. Senior staff told us the report and action plan had not been shared with clinical teams and was kept at high level.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They escalated relevant risks and issues and identified actions to reduce their impact. However, not all risks were identified in the first instance.

Service leads were fully aware of the risks across the service and had plans in place to address them. Risks and performance were being managed in line with service improvement plans and informed decisions regarding pathways and developments. The main area of concern was staffing. Additional risks were largely linked to the improvement of patient pathways.

There were systems and processes in place to identify risk. The maternity service had a risk register. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We looked at the risk register and risks were in date and had been reviewed.

The service had a detailed quality improvement plan which addressed areas for development such as pathways of care and staff culture. The team were being supported by the operational development team to address some of the areas. However, at the time of writing this report, no evidence had been provided by the trust to demonstrate progress with this.

Service leads were using Birth-Rate Plus to help with the management of acuity and workload. Staff were expected to submit data into the tool to enable the identification of pressure, however, staff reported that they did not always have time to complete this due to reduced staffing.

Although maternity staffing risks were mitigated by the movement of staff within the department the frequency of the implementation of the escalation policy was not clearly monitored. This meant that managers did not have clear oversight of the frequency of staff movement and the holistic risk of staff movement throughout the service was not captured nor was any potential financial impact.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The dashboard was not displayed in clinical areas, this meant staff and the public were not informed of the outcomes and risks of the maternity service.

We escalated our concerns around the risk to women within the triage assessment unit who were not being triaged within 15 minutes. This was not identified as a risk prior to our escalation of concerns, despite the service completing an audit of performance in the triage assessment unit over the last three months. Post-inspection, the service produced further information to demonstrate this had now been added to the risk register.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Arrangements were in place to ensure confidentiality of maternity patient records was robust. We found the trolleys and filing cabinets where patient records were stored at the midwives' station and were lockable. Computer screens were closed when not attended. Staff had password access to electronic systems.

Data or notifications were submitted to external organisations as required. The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). This enabled the service to benchmark performance against other providers and national outcomes.

Maternity

Managers demonstrated understanding of performance which looked at people's views with information on quality, operations and finance. Managers had a framework to oversee the quality and safety of patient care which included the maternity dashboard. They reported a range of service performance measures and discussed quality in governance meetings.

Engagement

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

The service usually worked with the maternity voice partnership (MVP) to improve the services for women. Some staff told us during the pandemic, this had reduced in the number of meetings they had and work they completed; however, this was likely to improve going forward as the impact from the pandemic improved. Staff told us they had good relationships with the MVP.

The safeguarding specialist midwife told us they engaged with several external organisations when providing care to women with complex needs. When the woman went into labour, the external organisations provided support to existing children to ensure the families stayed together.

The service was keen to encourage women to provide feedback on the service they received at the trust. Staff were looking at ways to improve the response rate to the friends and family test (FFT) as well as reviewing ways of receiving feedback internally. Staff were keen to improve the reputation of the service and therefore valued the feedback from women to help with this.

The service undertook the NHS Friends and Family Test (FFT) with inpatients. The results of the FFT were reported back to staff each month. All inpatients were asked how likely they were to recommend the ward to friends and family. The feedback from the FFT question for maternity services, on average, did not meet the trust's target of 94%. Data provided post-inspection showed that the target was only met once in a 12-month period, indicating not every person who undertook the test was positive about their experience. However, the response rate for the FTT was consistently above the trusts target of 18%. In a 12-month period, the trust had surpassed this target in every month.

Staff within specialist roles and mangers engaged with staff in different ways to ensure they were up to date with some key information. Examples of this included but was not limited to; a newsletter a matron produced for staff, the digital newsletter from the specialist midwifes and digital team and the maternity and neonatal newsletter.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff we spoke with all showed a desire to improve the service for the women they provided care and treatment for. Staff spoke of the challenges in relation to learning and improving the service.

Learning from staff feedback and reviews of practice had led to the development of a daily l huddle to improve timely reviews and the safety of babies.

The professional midwifery advocate (PMA) had submitted an abstract poster presentation to the Royal College of Midwifery (RCM) in the 2022 RCM conference.

Maternity

The practice development midwife (PDM) had organised a joint training with the London Ambulance Service (LAS) on emergency training, staff said this had helped equip their knowledge and relationship building and learning.

Staff told us the hospital was planning to introduce a patient safety summit to help in dissemination of information and learning from incidents.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure staff complete mandatory training in line with the Trust's own target. Regulation 12(1)(2) (a)(c).
- The trust must ensure staff adhere to control measures to protect women, themselves and others from infection. Regulation 12(1)(2) (a)(d).
- The trust must ensure equipment is checked in line with Trust policy and documented clearly. Regulation 15 (1) (2) (c)(d) (e)
- The trust must ensure staff complete timely risk assessments for each woman and take action to remove or minimise risks. Regulation 12(1)(2) (a)(c).
- The trust must ensure all staff record all information relating to patient care and treatment is clearly documented. Regulation 12(1)(2) (a)(c).
- The trust must ensure waiting times and other key metrics are in line with national standards. Regulation 12(2)(b); 17(1) (2) (e)
- The trust must ensure complaints are handled in a timely way and in line with Trust policy. Regulation 16 (1)(a)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one inspector, three specialist advisors and one clinical fellow working for CQC. The inspection team was overseen by Nicola Wise, 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 Surgical procedures Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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