Dartford and Gravesham NHS Trust

Darent Valley Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Darent Valley Hospital

Good 

We inspected the maternity service at Darent Valley Hospital 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.

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

Dartford and Gravesham NHS Trust provide maternity services at Darent Valley Hospital and local community services. The maternity service supported 4,704 mothers to birth and 4,757 babies were born in 2021. This included 52 sets of twins.

Maternity services include:

- Antenatal Clinic
- Mixed antenatal and postnatal ward (Cedar ward)
- Postnatal ward (Aspen ward)
- Fetal Medicine Unit
- Home from Home Birth Centre
- Labour ward
- Triage (Tambootie ward)
- Community midwifery
- Special Care Baby Unit (Walnut ward)

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

We did not rate this hospital at this inspection. The previous rating of good remains.

How we carried out the inspection

We visited all areas within the hospital birth centre. We spoke with 13 mothers/partners and 41 members of staff. We reviewed performance information about this service before we visited. We reviewed 8 sets of maternity records and 4 prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, incidents and audit results.

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

Good 

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Our rating of this service stayed the same. We rated it as good because:

- The service had enough medical staff and generally had enough midwifery staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.

Maternity

- Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

- Notes were not always stored securely. Not all staff had completed mandatory training including fetal wellbeing, medicines management and they did have sufficient theatre staff to scrub for elective caesarean sections on every weekday. Not all staff were bare below the elbow, and some clinical curtains had not been changed to reflect their policy, although they looked in good order. There were occasional gaps in daily checks of emergency equipment.

Is the service safe?

Requires Improvement 

Requires improvement

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

Mandatory training

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

The trust had a three- year maternity training plan. This was developed around the national core competency framework. Mandatory training included but was not limited to fire safety, equality and diversity, information governance, and emergency skills and drills.

Annual cardiotocograph (CTG) training was mandatory for all midwifery and obstetric staff. Staff were also required to complete an assessment following training to ensure they were competent to interpret CTGs. However, only 72% of midwives and 67% of consultant obstetricians had completed this for the past 12 months. Learning to support fetal monitoring was also supported during weekly meetings to discuss recent cases of interest. During the factual accuracy period the trust provided an updated implementation plan which showed by December 2022 97% midwives and 100% of consultant obstetricians would be trained in fetal wellbeing if all planned study days went ahead.

Face-to-face training had changed to virtual during the start of the COVID-19 pandemic. They had used a range of tools to ensure it was still interactive. This included videos, virtual reality and staff quizzes. Simulation based training was included within skills and drills training days. Live drills were performed in all areas of the unit and involved the multidisciplinary team. Training was multi-disciplinary to improve time spent together and team building

However, not all staff attended training relevant to their role. For example, 86% of midwives, 75% of consultant obstetricians and 53% of consultant anaesthetists had attended mandatory skills and drills for the past 12 months. During the factual accuracy process the service provided an updated implementation plan which showed by December 2022 98% of midwives, 100% of consultants and 100% of consultant anaesthetists would have attended multidisciplinary skills drills and adult/ neonatal resuscitation training, if all planned study days went ahead.

Staff received mandatory training in medicine management annually. Compliance was 63 % for the previous months. Reduced compliance for mandatory training was initially in response to the COVID-19 pandemic and currently due to subsequent staffing pressures. During the factual accuracy period the trust provided an updated implementation plan which showed by December 2022 all staff will be compliant with mandatory training if all planned study days went ahead.

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 this mandatory training.

Maternity staff received training specific for their role on how to recognise and report abuse. The service had a safeguarding lead midwife, who had completed a master's degree in child protection and were trained to safeguarding level 4. Midwives and obstetric staff were trained to safeguarding level 3 and maternity support workers and theatre staff were trained to safeguarding level 2. This was in line with the intercollegiate guidelines (2018). However, the training compliance for midwives and obstetricians was 63% at the time of our inspection. This was against a target of 95%.

Training included a general update on domestic abuse, ill mental health, risk assessments and how to make referrals. Training also included staff wearing virtual reality equipment to simulate the impact of domestic violence on an unborn baby. Board members experienced the training as part of ward to board presentations.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff discussed safeguarding concerns at handovers in all clinical areas. The multidisciplinary meetings and sharing of information helped to ensure they interacted and coordinated their efforts to diagnose, treat and plan for vulnerable women and families.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. We attended a safeguarding hub monthly meeting. There was good representation which included the safeguarding specialist midwife, drug and alcohol specialist midwife, health visitors, social workers, community midwives, neonatal staff, hospital independent domestic violence advocates and representation from local women's aid. The team also had close involvement with drug agencies and referral pathways. There was effective communication and clear recommendations and actions.

Staff did not record safeguarding concerns in women's handheld notes as this could place women at risk. Staff recorded safeguarding concerns on electronic records, accessed only by those who needed it. A flag was raised on the woman's record to alert staff and ensured they were aware of the concerns.

Staff reported there had been an increase in the number of women reporting domestic abuse during the pandemic. The safeguarding team provided regular updates on domestic abuse, as part of mandatory training days. Staff recorded enquiries, disclosures and referrals about domestic abuse which ensured perpetrators could not access it.

Maternity

We reviewed 8 care records. All women were routinely asked about their mental health and domestic abuse on more than two occasions in pregnancy and following birth. The service was assured midwives were identifying women in abusive relationships to support them and their unborn baby to stay safe.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect women, themselves and others from infection. We saw some dust in the triage area, although other areas were visibly clean.

Staff received mandatory training in infection prevention and control (IPC). As of September 2022, 96.6% of maternity staff had completed IPC training at Level 1, and 94% at level 2.

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of PPE, which was stored on wall mounted displays. Hand sanitiser gels were available throughout the service. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks. Hand hygiene audit results were completed for all clinical areas. Results for June to August 2022 were between 99 and 100% across maternity services.

However, not all clinical staff were seen to be bare below the elbow. Some staff were wearing rings other than plain bands. This could affect the ability for effective hand washing. We highlighted this to management who told us they would address this issue immediately.

The premises had suitable furnishings which were clean and well-maintained. Cleaning records were up-to- date. The service performed enhanced and more frequent cleaning of all areas to prevent the spread of COVID-19, in line with national guidance. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

However, we noticed dust on the bottom of equipment and also in the floor corners in the bays alongside the triage area. Health cleaning professionals changed curtains every eight months. We saw one set of curtains had no replacement dates, but looked in good order. Not all bays curtains were dated in Aspen ward, although they were dated in all other clinical areas. We highlighted this to management who advised they would deal with the matter immediately.

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.

The service had suitable facilities to meet the needs of women and families. Departments within maternity services were secure. Apart from triage, they were all accessed through a secure intercom system. All visitors were asked to identify themselves before they were allowed entry. This included triage area. CCTV was present in all communal areas.

Labour ward

The service had enough suitable equipment to help them to safely care for women and babies. The labour ward included a reception area with comfortable seating for women and their birthing partners. There were eight labour/birth rooms with ensuite facilities. One room included a pool for labour and birth. All rooms had recliner chairs for partners/ support people and facilities for women to aid labour. For example, birth balls, birthing stools and bean bags.

Each room included a computer so staff could maintain contemporaneous notes, without leaving women. They also included a cardiotocograph (CTG) and infant resuscitaire. They had enough suitable equipment to care for high and low risk women during labour and birth.

There were two obstetric theatres for elective and emergency caesarean sections and other obstetric procedures. They were staffed and managed by two midwives, operating department practitioners and anaesthetist staff.

Birth Centre

The birth centre was designed for women who were low risk. It had two labour/birth rooms and one for very early stages of labour, known as the latent-stage-of-labour room. Rooms were designed in a homely, non- clinical way. They looked comfortable and spacious, with mood-lighting, battery operated fairy lights and candles, and calming murals on their walls. The birth centre included a four-bedded bay for women who had given birth. This included facilities for partners to stay.

Both labour rooms included a pool for labour and birth. However, one pool had not been in use for eight months. This was due to water contamination. They had not been able to identify the root cause for the contamination. This was despite a thorough and ongoing investigation, led by their infection prevention and control team, this was not on the service risk register. We were told this was because the service had not had to decline the pool to anyone for labour or birth. We saw there was no associated infections or adverse incidents related to this. The service was also able to offer women an inflatable pool as an alternative.

There was a resuscitaire and emergency equipment situated within easy reach of each room and had enough suitable equipment to care for low-risk women during labour and birth. The birth centre was situated next to the labour ward. This meant women could be quickly transferred if they developed complications. The special care baby unit (Walnut ward), was opposite the labour ward. Mothers and babies could be quickly transferred in an emergency.

Antenatal and Postnatal

There was a mixed antenatal and postnatal ward called Cedar ward, and postnatal and transition care was on Aspen. High risk mothers and postnatal readmissions were transferred to Cedar ward. There were four bays which included four beds in each bay and four single rooms. Each bay had a toilet and single rooms were ensuite. There were communal showers on the ward. There was a bedside TV and telephone for each bed.

There was an infant-milk kitchen on Cedar ward. This included a milk-fridge for mothers to store expressed breast milk (EBM), for their baby. EBM was stored in sterile syringes or bottles and labelled. The name, hospital number, date and time expressed were written clearly on all labels. The room to the milk kitchen and the milk-fridge were not locked. Staff told us this had been risk assessed and it was to enable mothers to access it when needed. The kitchen also included a fridge to store donor milk. This fridge was locked. The milk fridge was clean and temperature checks were completed for both fridges to ensure breast milk was stored safely. However, the milk fridge was not checked on 3 and 5 October 2022.

Triage

The triage area was called Tambootie ward and was open 24-hours a day. It catered for women from 18 weeks of pregnancy up to six weeks postnatally who were feeling unwell or experienced any problems/complications of pregnancy, labour assessments, or postnatal problems.

Maternity

Serenity suite

The maternity service had a specific suite for women and families who had experienced a baby loss. It was called the Serenity suite. The area included a dedicated bereavement room in a secluded area, with a separate entrance. It was located away from the labour ward and birth centre so that it offered families a private and comfortable space to grieve the loss of their baby. The room was occupied during our visit, so we did not go into the area.

The Serenity suite was staffed by labour ward staff, supported by the bereavement midwife. The bereavement midwife managed the service, led on bereavement training and supported labour ward staff to care for bereaved families. The service had a bereavement support team as recommended by the stillbirth and neonatal death charity (SANDs) best practice; Five ways to improve care for parents whose baby dies before, during or shortly after birth (2016).

The Serenity suite was recently refurbished to include soft lighting, a double bed and sensitive murals, but we were told there were no windows and the room was small. The room included food storage, and refreshment facilities. It also included cold cots and cuddle cots, a memory box for parents to make special keepsakes and spend precious time with their babies.

The bereavement specialist midwife offered mothers who had experienced baby loss follow-up support and ran a support group for them.

Managers ensured all specialist equipment was serviced and calibrated. They maintained oversight of equipment to ensure it was safe and ready for use. Equipment had up-to-date safety testing. Consumables were stored securely and were all in date. Records demonstrated staff carried out daily safety checks of specialist equipment.

Equipment was provided to assist staff with the safe evacuation of a woman from the birthing pool. The service provided training in how to use the equipment.

There were two resuscitation trollies which were located so that all areas had easy access. All clinical areas had an emergency trolley for obstetric emergencies. We checked the emergency trolley in triage and the postnatal ward. There was evidence that daily checks had been completed to ensure all items were present and in-date.

Staff were required to check the resuscitaire trollies daily to ensure the security seals were intact. These were expected to break the seal weekly, check the entire contents and then reseal the tag. Trollies had to be cleaned, re-stocked and re-sealed after clinical use. However, we saw gaps in the checks. For example, one resuscitaire had not been checked between the 1-4 October 2022. Audit results for daily safety checks ranged between 97-100% for September 2022. We also found gaps in daily checks of emergency equipment on Aspen ward between 18-29 September 2022.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Sharps bins were no more than three-quarters full. The date opened was stated on the bins and within three months of expiry in all areas. Arrangements for control of substances hazardous to health were adhered to.

Assessing and responding to patient risk

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

Maternity

We reviewed 8 maternity care records. The lead professional was confirmed in 7 out of 8 cases and risk factors were highlighted. Women were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Seven out of 8 women had risk assessments completed at every contact and there was evidence of appropriate referral.

Carbon monoxide screening was performed in each set of notes reviewed in line with best practice guidance. Staff risk assessed every woman's risk of venous thromboembolism at booking, on arrival in labour, and during post-natal care. This was in line with national guidance.

Staff monitored the baby's growth, and accurately plotted this. Staff identified babies that were not meeting their growth potential, as they would be at higher risk of complications. Women were screened for safeguarding concerns and staff used the information to plan care and involve the right staff.

Staff ensured women understood the importance of vitamin D supplementation and monitoring their baby's movements from 25 weeks of pregnancy.

Staff booked interpreters for planned face-to-face appointments. They used a language interpreting telephone service which could be available 24 hours-a-day for unplanned contacts. If there was an emergency involving a non- English-speaking woman, they communicated a 'shout-out' across the trust to determine if any staff member spoke the required language.

Women who chose to give birth outside of guidelines were supported. They were offered an appointment with a consultant obstetrician and/or an appointment with a professional midwifery advocate (PMA). The PMA discussed the woman's decision, and they agreed a birth plan. The aim was to support their choice and ensure everything was planned to ensure the birth was as safe as possible. PMA's were available to support midwives caring for women outside of guidance. Midwives told us the teams worked together well to support informed choice. Midwives felt well informed and well supported in these situations.

All women who attended triage were RAG rated into red, amber or green dependant on their clinical need and urgency. Staff contacted the obstetric on-call team if a woman needed urgent review. They told us obstetric staff attended immediately. There was a protocol to guide staff for women who needed an emergency transfer from triage to labour ward/theatre. This was captured on their daily hand-written forms. There was no audit to review the effectiveness of the service such as the time of arrival and the time women were assessed.

All babies wore coloured RAG (red, amber, green) hats for the first 24 hours after birth. The traffic- light hats were a visual aid for staff to easily identify babies that needed a little more care/review, in the first 24 hours after birth.

The service monitored readmission rates and fed back any issues and learning to staff and updated policies and practice as necessary.

There was a robust process for women who were booked for elective caesarean sections to ensure it was safe for women to proceed with their planned surgery.

The service used 2 different handover tools. One was for handing over to other staff and the other for handing over to other organisations.

Maternity

The service developed a structured communication tool known as HAND; this was developed following an incident in 2018. During the factual accuracy period we were provided with an audit which showed the tool had been completed appropriately in 61% of records reviewed. Midwives were orientated to the tool as part of their induction. The format was structured to include:

H = History

A = Admission, reason for

N = Needs to be done (tick when done)

D = Discussion with/ management plan

In addition, staff also used the nationally recognised situation, background, assessment, and recommendation handover tool known as SBAR for in-utero transfers. SBAR consisted of standardised prompt questions in four sections to ensure staff were sharing concise and focused information. It allowed staff to communicate effectively, reducing the need for repetition and the likelihood for errors. However, this was not audited.

We observed staff handovers in all clinical areas. Staff were encouraged to contribute, and there was effective communication and shared learning.

Safety huddles occurred three times a day. They took place on the special care baby unit to ensure neonatal staff were able to attend. The maternity bleep holder attended every huddle to help ensure they had oversight of the unit. Huddles included necessary information to keep women and babies safe.

Midwifery Staffing

The service did not always have enough maternity staff. Staff had 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 staff a full induction.

Safe staffing in maternity was regularly reported to the quarterly public trust board meeting. The service had a recruitment and retention plan, which included a review of their maternity support worker establishment, roles and banding. This was aligned to the Birthrate plus recommendations for midwife to support worker ratio and improve the quality of experience for women and families.

The planned number of midwives on every shift was 17 for the whole maternity unit. However, the service was under-staffed by three midwives on 24% of shifts in August, and four on 6% of shifts.

There was a lack of staff to scrub for caesarean sections on 2 days a week. This was also the top risk for maternity. Main theatre staff supported the gap, but they could not provide full cover. Midwives who were trained and deemed competent to scrub were used to cover the shortfall. However, this could compromise overall staffing for maternity services. The service was trying to recruit additional staff and a successful business case had been approved to support this.

Maternity

One hundred percent of women received one-to-one care in labour during August and September 2022. The labour ward coordinator was supernumerary to maintain a helicopter view of the area. They monitored compliance to the supernumerary status of the coordinator and one-one care in labour to keep women and babies safe.

We asked the service to provide evidence of NICE red flag events, however, we did not receive this. During the factual accuracy process the service provided evidence which showed there was oversight of red flag events; however, this evidence was supplied over 3 reports and was not specifically identified as red flag events. Therefore, we could not be assured of the effectiveness of the oversight.

The service had up-to-date policies in escalation and closure of the unit to support safe staffing. These ensured senior managers and clinicians were informed and involved during periods of high acuity and activity. They also shared staffing concerns with the site matron and rest of the trust.

The escalation policy supported the redeployment of staff within maternity to areas most in need. The service also transferred staff from the community midwifery teams to support safe care. The service used bank staff when required. The escalation plan also gave scope to stop activity within the birth centre. The birth centre was closed on two occasions in the week prior to our inspection, 6 times in August and 7 in September 2022. The continuity-of-care teams had been suspended until staffing levels had improved following guidance national guidance.

Maternity staffing levels were discussed at all safety huddles. Additional safety huddles were called as required. Senior midwifery staff attended the safety huddle if an escalation occurred. The coordinator triggered the escalation process if staffing numbers were unsafe and spoke with the site nurse practitioners to keep them informed of the situation.

The professional midwifery advocate (PMA) team provided an on-call service for staffing the unit and remote support. This model had been the safest way to maintain safety during a period of high vacancy. The on-call PMA could escalate to the named senior manager on-call. The service had completed a project to review the PMA role and determine who was most suited to provide on-call support. The proposal(s) had been through a consultation process which had not yet concluded.

The PMAs were responsible for implementing the A-EQUIP Model (advocating and educating for quality improvement). This model aimed to support midwives through a process of restorative clinical supervision and personal action plan, for quality improvement. Midwives had access to support from their PMAs and were encouraged to meet them when training needs were identified.

The PMAs met monthly to discuss any staff that needed additional support and agreed how they could support them. They disseminated any national information or updates. For example, information from the Nursing and Midwifery Council and NHS England information. The PMAs worked effectively to support women and midwives

The service made sure staff were competent for their roles. Practice development midwives (PDMs) were responsible for ensuring any concerns with staff competence were effectively escalated to their line manager. PDMs worked with line-managers to support staff when competence issues were identified.

The service gave bank staff a full induction and ensured they completed all mandatory training. New starters had a comprehensive competency-based induction programme to ensure staff had the clinical skills to provide safe care.

There was a preceptorship programme for newly qualified. The programme adopted a blended learning approach which included study days, electronic learning modules and reflective sessions. Preceptored midwives rotated across the services monthly. The learning supported their transition from student to qualified practitioner. Newly registered staff were appointed a preceptor by their line manager. The preceptor acted as a professional role model and met with their preceptee twice a week. They supported their learning and development throughout the first 12-months of their career.

Staff were supported to develop through yearly, constructive appraisals of their work. We were given examples of how staff had been supported to develop. Eighty five percent of staff had received an appraisal at the time of our inspection. Maternity services had met their compliance target for appraisals which was part of a rolling programme.

Managers engaged with Health Education England's programme of work to support maternity staffing. The maternity service received £200,000 during 2021/22 to support recruitment, retention and clinical supernumerary support. The trust had used this to fund a senior recruitment, retention and wellbeing post. They had also introduced clinical wellbeing midwives onto a proportion of shifts with a focus on retention for less experienced staff.

Maternity services had three maternity support workers (MSW) seconded onto the Midwifery Apprenticeship Programme. One MSW was expected to be the first to successfully qualify in January 2023. Funding had been agreed through their business planning process.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. Twelve consultants contributed to the obstetric rota. We were told there were no gaps in the rota. The consultants were supported by middle grade doctors and trainees. Managers could access locums when they needed additional medical staff.

Medical staffing was monitored by the clinical director to ensure it was compliant against royal college of obstetrics and gynaecology recommendations. Consultants covered labour ward for 92 hours per week in August and September 2022. They were on site from 8am to around 8-10pm, 7 days a week. Consultants led multidisciplinary ward rounds on labour ward, 3 times a day and were required to be within 30 minutes of the unit if they were needed out-of-hours.

Obstetric staff received three days protected induction. This included skills and drills, fetal monitoring training, and an assessment, which they had to pass. Senior registrars were buddied to junior registrars to support junior staff. Managers could access locums when they needed additional medical staff.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. One hundred percent of medical staff had an appraisal in the previous 12 months.

The clinical director promoted well-being and support for exception reporting. Junior staff had protected time included in their working hours for learning. Staff told us consultants were visible, available and supportive. There was an emphasis on learning and improvement and supporting colleagues.

Consultant anaesthetists with a special interest in obstetric anaesthesia were present on the labour ward for ten sessions per week. This was from 8am to 6pm, Monday to Friday. Their leave of absence was covered internally by

another consultant anaesthetist with a special interest in obstetric anaesthesia. These consultants also led the assessment clinics and supervised the training of anaesthetic junior doctors. A consultant anaesthetist with a special interest in obstetric anaesthesia was rostered to perform elective caesarean sections from 8am to 1pm, Monday to Friday.

Out-of-hours and weekend cover was provided by a resident specialty doctor or trainee who had the required competencies and experience. They were supported by a consultant anaesthetist who was contactable and able to attend if required.

Records

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

Staff kept records of women's care and treatment. We checked 8 sets of maternity care records and saw they were all dated, timed and signed. Potential safeguarding issues were flagged electronically so all clinicians could recognise and act on safeguarding concerns. Women's care records were comprehensive, filed neatly, and in a set order.

Records were not always stored securely. Some antenatal and postnatal records were paper based. Paper records were stored in an unlocked trolley on the mixed antenatal and postnatal ward. This meant confidential information could be accessed by non-clinical staff and members of the public. We highlighted this to managers who dealt with this immediately.

The discharge process was electronic. Discharge information was recorded electronically and triggered an alert to the relevant GP and community midwives. Child health records (Red books) were given to mothers on discharge. Mothers who lived out-of-area received them from their community midwife.

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.

Staff completed medicine records accurately and kept them up to date. We reviewed the medicine records for 4 women. Prescriptions were legible, named, dated, allergies and weight were clearly documented, and administration and route of administration were also clearly recorded.

Records for checking controlled drugs demonstrated that the medicine policy was followed. Records showed two staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Clinical fridge temperatures were maintained between a minimum and maximum recommended temperature They were checked daily to ensure required medication was stored at the correct temperature to maintain drug efficacy. Compliance to their medicine management policy was 96% between April and September 2022.

Some drugs were not locked away. For example, in the epidural trolley. We highlighted this to managers, who, advised that a risk assessment had been completed and the policy was to have certain drugs unlocked to be quickly accessible, We did not ask to see this risk assessment.

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. When things went wrong, staff apologised and gave women honest information and suitable support.

Staff knew what incidents to report and how to report them. There was a clear process which all staff we spoke to understood and followed. The trust used an electronic reporting system which all grades of staff had access to. Everyone understood their responsibility to report all incidents that they felt could affect safety

Managers debriefed and supported staff after any serious incident. We were given several examples of how staff had been supported. Staff received a hot debrief immediately following an incident. Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event and has the advantage of earlier intervention, improved participation and improved recall of events. The process for investigating and managing incidents was based on learning and improvement, not or apportioning blame.

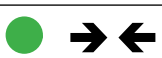
Staff felt well supported by colleagues, management and the wider team when they were involved in an incident. They received swift support and were given options. In addition to their team and line manager this could include their professional midwifery advocate or manager.

Staff with different roles and grades gave recent examples of how they had felt well supported following a clinical incident. Mangers and midwives in charge of shifts also considered colleagues wellbeing, especially when they had worked a difficult shift. Psychological support and safety were routinely considered as part of investigations into clinical incidents.

Staff received feedback following incident investigations and themes from incidents were shared. There was a staff update board in all clinical areas. This included a variety of clinical information to update staff. For example, themes from incidents, learning identified, and good practice was highlighted. It also included reminders about key changes to guidance or practise. Themes were also shared to all staff groups by email, summarised in a monthly quality newsletter and shared at handovers and huddles in all clinical areas.

Staff understood the duty of candour (DoC). They assessed the application of the DoC against all incidents and maintained and monitored compliance.

Is the service well-led?

Good 

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

Leadership

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff.

The leadership team prioritised the safety of their maternity service. They had two board level champions who regularly reviewed the measures of quality. Safety was a priority item at board meetings. The board would act if necessary. They promoted collective leadership and a culture of multi-professional working and learning.

The maternity service worked as part of a Local Maternity System (LMS), to ensure services were provided to meet women's choices and ensure women and babies were kept as safe as possible. Specialist care was accessible when needed, and they operated under shared clinical governance and protocols,

There was a collective leadership approach rather than a directive approach. The leadership team created conditions for high levels of staff engagement in supportive, appreciative environments while ensuring staff were accountable for safe, compassionate care.

There was a clearly defined management and leadership structure in place. We were told of joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The senior leadership team was formed of a director of midwifery (DoM), divisional (clinical) director and chief nurse. The DoM reported directly to the chief nurse. The DoM was supported in their role by the deputy head of midwifery. The team was also supported by midwifery matrons and band seven lead midwives.

The maternity service worked together as part of an LMS to ensure services were provided to meet women's choices and ensure women and babies were kept as safe as possible. Specialist care was accessible when needed, and they operated under shared clinical governance and protocols.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board and or the executive team. The DoM attended board meetings and presented any midwifery papers/reports. This included a quarterly update on their Ockenden gap analysis and progress. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies.

Staff told us senior managers were visible and available. The safety champions completed regular walk-arounds. They were knowledgeable about the service, and proactive about holding the leadership team to account. Staff found them approachable, and keen to hear their views and experiences, to drive improvement.

Vision and Strategy

The service had a vision and strategy in draft for what it wanted to achieve which was developed with all relevant stakeholders.

Maternity services worked collectively during the pandemic to determine what they wanted their vison and strategy to be. They shared their vison with the public and incorporated their feedback. This was in draft format whilst they were awaiting feedback on the best way to market this.

Culture

Maternity

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

The culture within maternity services supported staff to develop and fostered a culture of learning and improvement. Leaders led by example and acknowledged that their behaviour(s) percolated through the service. They strived to ensure the tone of meetings was about promoting openness and honesty to seek learning and assure themselves that learning was embedded.

We spoke to staff across most grades and disciplines. Staff told us they were proud to work for the trust and they felt valued and respected by management. Management operated a system to nominate staff for a monthly award known as the maternity star monthly awards. Two members of staff received chief midwifery awards around the time of our visit. This was in recognition of performance that went over and beyond the everyday role that a midwife was expected to perform

They described healthy working relationships where they felt respected and able to raise concerns without fear. Staff told us the culture was one of learning, not blame. The trust employed a Freedom to Speak up Guardian (FTSuG), and Freedom to Speak up Ambassadors to support staff who wished to speak up about a concern or issue. The FTSuG were not employed directly by the maternity service. They ensured any issue raised was listened to and feedback was provided to them on any actions or inactions because of them raising an issue.

The service promoted equality and diversity in daily work and provided opportunities for career development. In November 2020 an initiative was launched called maternity, equality, diversity and inclusion (MEDI). The aim was to ensure maternity services were appropriate, sensitive, non-discriminatory and had equal access for all.

The midwife who led on the initiative won an award in October 2021. This was in recognition of their achievements in diversifying maternity care for expectant mothers from ethnic minority groups. This included promoting anti-racist behaviour, and challenging bias. They were also instrumental in establishing a vibrant and diverse MEDI.

The service was looking at more suitable venues to engage with women who could be harder to reach. For example, community and religious centres. Cultural competency was weaved into training, such as the importance of understanding identity. For example, asking a pregnant woman or mother how to pronounce their name. The service recognised the importance of all staff understanding and respecting cultural difference.

The service clearly displayed information about how to raise a concern in women and visitor areas. Information was clearly displayed on information boards in all clinical areas. This included various options. For example, emailing the professional midwifery advocates, the maternity voice partnership, patient advice and liaison service, the debriefing service or the maternity Facebook page.

Managers investigated complaints and identified themes. Complaints were fed back to individuals to help them understand the parent's perception of their care. They were presented at maternity study days to share learning. Themes were shared at handovers, huddles, on staff notice boards, their governance newsletter, and by email. A complaints folder was maintained on the shared drive so that all staff could review women's concerns and responses. Complaints were presented to monthly divisional governance and directorate risk meetings.

The service hired an external company to re-vamp the maternity website. This project was led by the parentcraft team. The aim was to improve information and support informed consent for all women and families.

Maternity

The service had implemented a personalised care guideline to keep staff focused on individualised care for individual women and their families. Staff centred on the woman, her baby and her family, based around their needs and their decisions. Women were offered genuine choice, informed by unbiased information.

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.

Information was captured and used to monitor the quality of the service provided. The maternity dashboard captured information on workforce, maternity morbidity, perinatal morbidity and mortality, readmissions, maternity safety, and public health data.

This information was reviewed at the maternity clinical governance meetings. Some information was also presented in the trust integrated performance report. This was reviewed by the board and executive team. Specific maternity papers relating to national schemes and reports such as the maternity incentive scheme and Ockenden reports (2020, 2022) were presented to the board. Staff were able to access information to help them form a judgment about the quality of the service.

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. There were clearly defined reporting avenues. Incidents, risks, performance, guidelines, audits and user experience were discussed at service governance meetings. These fed into divisional meetings which then escalated to trust wide committees through to the subcommittees of the board.

Maternity services had an audit midwife who managed their maternity audit programme and quality projects for 2022-2023. This included approved quality projects, national and local audits and service evaluations. The service participated in four national audits which included national pregnancy in diabetes audit, national maternity and perinatal audit and the UK obstetric surveillance survey. They participated in the national confidential Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK.

All band 5 midwives completed an audit as part of their preceptorship programme. The staff identified an audit in an area of chosen interest and presented findings which included recommendations for service improvement. The audit midwife maintained oversight of all live audits and supported staff to ensure they were completed, presented, met deadlines, and actions were agreed.

The service held a monthly quality and shared learning meeting. These meetings were an open forum for all obstetrics, gynaecology and midwifery staff to review statistics and trends. Approximately 50 staff attended as they could join virtually. Clinics were curtailed to ensure staff had the opportunity to attend and they were accessible to all.

The service ensured any recommendations and learning outcomes from case presentations and audits were discussed and reported to the trust clinical leads audit committee. This committee ensured that management responded to findings and issues identified by audit activity.

Maternity

The maternity forum met monthly and reviewed guidelines/polices that needed updating. Updated guidelines were communicated to all maternity staff in a structured manner. New or updated user leaflets were also reviewed, updated and disseminated. There was a process to maintain oversight of guidelines/policy reviews to ensure they were up-to-date and reflected best practice and national guidance.

Management of risk, issues and performance

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

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

The trust monitored the number of incidents and serious incidents that staff reported monthly. Governance and risk leads joined up with leads across Medway and Kent to identify learning from incidents across the local maternity and neonatal system.

The trust was open and transparent and gave women and families a full explanation when things went wrong. Staff explained what had happened and apologised. The trust assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard.

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.

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 service was in the process of introducing a digital journey board system. This was expected to be embedded into maternity services by April 2023. This would support electronic-noting and clinical decision making and proactively suggest appropriate actions and automate routine tasks for clinical teams under pressure. The journey board system would automatically capture data such as the time women presented to triage, the time they were triaged, the time they had an obstetric review and decision making occurred.

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

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

Maternity

Managers told us they collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women's care. Managers also used this information to inform decisions around service delivery such as continuity of care teams and community caseloads.

Engagement

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

The service collaborated with partner organisations to help improve services for women. They took account of the views of women through the Maternity Voices Partnership (MVP). They were in the process of recruiting an MVP chair as their previous one had recently left. There was an interim chair acting-up until the vacancy was filled.

Historically, meetings were well represented by different staff groups. There was a commitment to work with the MVP and local women to design services to meet their needs. The MVP worked with maternity services to bridge any gaps with women that could be harder to reach. There was a staff event organised for the day after our visit. It was to celebrate black history and included food and makeup sessions for staff as part of the celebrations.

The trust used social media platforms to connect with women, raise awareness, and act as their advocate. The trust valued their partnership working with the MVP and monitored their engagement.

The service had worked with their local MVP to co-produce leaflets, posters and changes to handheld notes. Leaflets were in an array of languages and available via QR codes.

The service co-produced surveys and reviewed feedback together. This had led to changes in guidelines and processes. They were also included on the interview panel for senior appointments. For example, for the interview of the director of midwifery position.

They hired an external company to re-vamp their maternity website. This project was led by the parentcraft team who were gathering relevant information. The aim was to improve information and informed consent for women and families. They engaged with women prior to developing online parentcraft classes and a maternity Facebook page.

There were systems in place to engage with staff. There were staff and student information boards in all clinical areas. This included details of how to contact the maternity safety champions, the Freedom to Speak up Guardian, where staff could get support and a box where staff could make anonymous suggestions for improvement.

There were information boards on corridor walls in all clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint and give feedback. Boards also included photographs of staff with their name and role.

Leaders prioritised staff wellbeing. There had been a recent staff engagement event outside hospital to understand how managers could support staff wellbeing. Staff wanted communication to be brief, so they did not feel overloaded. A wellbeing APP had been developed which helped to keep communication brief. Social media was used to keep staff focused and engaged. Leaders communicated to all staff in a modern way that staff responded to.

Maternity

Learning, continuous improvement and innovation

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

The trust developed maternity training pathways during the COVID-19 pandemic. The trust moved to virtual training and developed innovative techniques to engage differently with staff and families. This included a YouTube video, presented by all staff groups in maternity. They wanted to reach out to women and reassure them that despite the pandemic, they were not alone. They reassured families that maternity services were available and wanted to support them.

The service launched an APP for dads-to-be across Kent and Medway, called DADPad. The APP provided fathers with guidance on how to support and seek help (when needed), for their partners and themselves, as they adjusted to their new roles. It aimed to help individuals cope with the physical and emotional strains fatherhood could place on individuals and relationships.

The service used a tea trolley imitative called 'talk and tea trolley' to gain feedback from staff and service users regarding potential improvements. It was also used to raise awareness about common issues such domestic abuse and other safeguarding concerns.

Maternity services were accredited with the baby friendly initiative in 2017. The services were due to be re-accredited in 2020 but the assessment had been postponed due to the COVID-19 pandemic. The service was preparing for re-accreditation at the time of our visit. They were committed to ensuring all mothers were supported to make informed decisions about how to feed and respond to their baby.

A smoking in pregnancy clinic was set up in October 2020. The clinic focused on risk perception as well as creating a holistic plan of care. The service was extended to Gravesend hospital where the prevalence of smokers was greater. This was in response to increased demand for the service and positive feedback from women who had used it.

The smoking in pregnancy midwife ran the clinic and was the first non-medical prescriber in the area of Kent and Medway. The non-medical prescriber was able to prescribe nicotine replacement therapy, without the need for women to see their GP.

There was a well-established diabetes multi-disciplinary team (MDT). This included a specialist midwife, diabetic nurses, consultant obstetrician, dieticians and endocrinologists. Pregnant women with type 1 and type 2 diabetes were seen regularly in the joint obstetric/diabetic clinic. The service had also trained a team of core midwives who had a special interest in diabetes (the Daisy team), to care for diabetic women during pregnancy.

The service participated in the national audit of pregnancy in diabetes and shared their results. Results showed the improvements in diabetic care following the initiation of their pre-conception clinic in 2018.

The service set up other specialist clinics during the pandemic. This included a clinic for pregnant women with asthma. The clinic was run by a specialist midwife, and also multidisciplinary service.

There was a debriefing service which supported women who had been traumatised by their birth experience. There was a dedicated team who were overseen by the birth options and maternal wellbeing midwife. The referral process had been simplified and had decreased the time women needed to wait for an appointment. Women could be referred by a health care professional or self-refer at any time. This could be years after they had given birth.

Maternity

The birth options and maternal wellbeing midwife was also a qualified practitioner in birth-trauma resolution therapy. They offered on-going support for women showing signs of post- traumatic stress syndrome, due to their birth experience. Feedback from women who had used the service was positive. The team were developing an additional survey from service-users to continually improve the service.

There was also a birth-options clinic. This had initially been set up to support women who had a previous caesarean section and wanted to consider a vaginal birth. Women were fully informed about all care options during pregnancy and were central to any decision-making regarding mode of birth.

Outstanding practice

We found the following outstanding practice:

- The service promoted equality and diversity with an initiative called maternity, equality, diversity and inclusion (MEDI). The aim was to ensure maternity services were appropriate, sensitive, non-discriminatory and had equal access for all.

Areas for improvement

MUSTS

Action the maternity service must take to comply with their legal obligations:

- The trust must ensure records are held securely (Regulation 17(c)).

SHOULDS

Action the maternity service SHOULD take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services;

- The service should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target.
- The service should ensure that all staff are always bare below the elbow and consider a process for the cleaning and changing of clinical curtains to reflect their policy.
- The service should ensure there is sufficient trained theatre staff to scrub for elective caesarean sections Monday to Friday.
- The service should ensure staff complete daily checks of emergency equipment, to reflect local policy.
- The services should consider auditing the time women arrive and the time women are reviewed/treated in triage, in advance of next years' digital improvement launch.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor and 4 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, 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

This section is primarily information for the provider

Enforcement actions

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