Maidstone and Tunbridge Wells NHS Trust

The Tunbridge Wells Hospital at Pembury

Inspection report

Tonbridge Road
Pembury
Tunbridge Wells
TN2 4QJ
Tel:

Date of inspection visit: 23 August 2023
Date of publication: 16/02/2024

Ratings

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

Our findings

Overall summary of services at The Tunbridge Wells Hospital at Pembury

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at The Tunbridge Wells Hospital at Pembury.

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

The Tunbridge Wells Hospital at Pembury provides maternity services to the population of 500,000.

Maternity services include an early pregnancy unit, maternal and fetal medicine, outpatient department, Maternity Day Unit, the Maternity assessment unit (triage), Antenatal ward, Delivery suite, Midwifery led birthing centre (Birthing Centre), two maternity theatres, the Postnatal ward (including Transitional care), an obstetric close observation area (OCOA), ultrasound department and an obstetric physiotherapy department. Between April 2021 and March 2022 5712 babies were born at The Tunbridge Wells Hospital, Pembury.

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

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

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

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Our rating of this hospital stayed the same. We rated it as Requires Improvement because:

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

We have since inspected 2 stand-alone birth centres run by Maidstone and Tunbridge Wells NHS Trust maternity services and the reports can be found here:

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

Our findings

Maidstone Birth Centre - https://www.cqc.org.uk/location/RWF03

How we carried out the inspection

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

We visited the Maternity Assessment Unit (Triage), Maternity Day Assessment Unit, Antenatal Clinic, Delivery Suite, obstetric theatres, the Antenatal and Postnatal ward which included transitional care.

We spoke with 15 midwives, 7 support workers including administrative administration workers, 4 Doctors, 5 women and birthing people and 2 birthing partners and or relatives. We received no responses to our give feedback on care posters which were in place during the inspection.

We reviewed 9 patient care records, 9 observation and escalation charts and 9 medicines records.

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

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

Maternity

Inadequate

We rated it as inadequate because:

- The maternity service governance processes and systems did not fully identify and manage incidents, risks and performance to reduce the recurrence of incidents and harm. There was a lack of audit to check any improvement needed had been achieved.
- The service did not always have sufficient numbers of suitably qualified staff deployed to reduce delays and risks of harm across the service, to women, birthing people and babies.
- Women and birthing people could not always access the service when they needed it nor receive treatment within agreed timeframes and national targets.
- The maternity triage did not have a standardised tool to complete risk assessments for women and birthing people on arrival. Midwives used their clinical judgement to assess and triage women.
- Staff were overdue completion of maternity mandatory training, including safeguarding and role specific training modules.
- The service did not always complete daily safety checks of emergency and specialist equipment.
- The service did not always control infection risk well as there were no established cleaning schedules for staff to use daily including for the birthing pool.

However:

- Staff understood how to protect woman and birthing people from abuse and managed safeguarding concerns well.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care.
- Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The bereavement facilities and care showed staff were able to recognise, respond and support individual needs of women, birthing people and families considering their personal choice, cultural and religious beliefs and needs.

Following our inspection, we served a warning notice asking the trust to make significant improvements on timely action of emergency caesarean births, risk management, and governance and oversight of the service. The service was required to submit an action plan, and we will continue to monitor progress in relation to this.

Is the service safe?

Inadequate

We rated it as inadequate.

Mandatory training

Maternity

The service provided mandatory training in key skills to all staff however not everyone had completed mandatory training updates or their role specific training.

Managers did not give staff time away from clinical duties to complete the training. Staff said that managers monitored mandatory training and alerted staff when they needed to update their training, but they could not complete all the training because of staffing pressures. The service monitored staff training attendance through the clinical risk management group. Compliance reports were submitted monthly by the practice development team. Staff said they received email alerts, so they knew when to renew their training. Total training compliance was not broken down separately for maternity and medical staff.

Staff were not up to date with their mandatory training. Records showed that 85% of midwifery staff and 87% of support workers had completed the required mandatory training courses against a trust target of 85%. The service told us staff were rostered for mandatory training and have been given the opportunity to claim bank hours to complete training if unable to complete within working hours.

We found maternity staff compliance for basic life support training was low for most staff groups and should be 100%. Although foundation doctors were 100% compliant, the service consultants and specialist doctors were 50% compliant and specialist registrars 55% compliant in this training. Only 72.2% of all maternity staff had completed training updates.

For level 2 immediate life support, only 66% of midwives had completed the training and only 64% of midwives had completed paediatric immediate life support training. The service has clarified that basic paediatric life support was not mandatory training for midwives. However, newborn life support was included in obstetric emergency training. This meant that staff did not have the appropriate level of training to provide lifesaving treatment to women and birthing people and babies in their care.

The service has highlighted that neonatal life support was included in multidisciplinary clinical skills training which covers various aspects of emergency care of which, 94% of midwives had attended.

The service told us 152 midwives and 28 obstetric doctors had completed cardiotocograph (CTG) training. However, we were unable to identify how many midwives and obstetric staff this was out of and whether the service was compliant with the service target of 85%.

Cardiotocograph training was completed by 82% of staff, for training on human factors and situational awareness and mandatory annual competency assessment compliance was 83%, which was below the service target of 90%.

92% of maternity multidisciplinary staff had completed skills and drills training and 92% had completed neo-natal life support training. 65% of maternity multidisciplinary staff had completed the Growth Assessment Protocol (GAP and Grow) e-learning, and 89% attended the workshop.

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

PRactical Obstetric Multi-Professional Training (PROMPT) training and live drills were all multidisciplinary and facilitated by a senior obstetrician, anaesthetist or senior midwife. PROMPT training compliance was 93.5% for midwives, 100% midwifery managers, 90% midwifery specialists,100% maternity support workers and 100% of nursery nurses

completing the training. Obstetric consultants were 88.2% compliant and other medical staff were below the service target. There was an obstetric competency review form to identify the level of competency the locum consultant had and to identify any specific obstetric training needs. Speciality doctors and speciality registers were 70% compliant in PROMPT training. The service had stated that there was a lack of teaching space for PROMPT training, as well as a lack of teaching staff. The service was looking at whether they could improve access for staff to attend training by providing larger teaching facilities across the maternity sites.

The service did not always actively support multidisciplinary training where this would improve the outcomes for women, birthing people and babies. Following inspection, we were told that training would be improved to focus on areas of highest risk of harm such as of postpartum haemorrhage and 3rd and 4th degree tears.

The service had a team of specialist midwives including practice development midwives who had oversight of training and development. The consultant midwife was the midwifery clinical lead and advised on midwifery education for the service. The team included three midwife practice facilitators and two practice development midwives. The team supported midwives especially newly qualified staff. The service had multiple specialist midwives including for bereavement, screening, governance, safeguarding, infant feeding and fetal well-being.

All medical staff in training had a compliance profile. Doctors in training completed self-assessment competency forms with their educational supervisor. This was monitored within the competency logbooks and discussed with their educational supervisor at least 8 times a year.

There was a training strategy for maternity services to provide a systematic approach to delivering maternity training for staff. The service monitored staff training attendance through the clinical risk management group. Compliance reports were submitted monthly by the practice development team.

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

The service provided a fetal surveillance study day which was based around case studies. The day was a multi professional training day. Local and national maternal outcomes played a focus on these training days using scenarios based on case studies. The day consisted of saving babies lives update and human factors training.

From April 2023 to June 2023 information received showed that only 56% of medical and maternity staff at the hospital had completed growth assessment protocol/gestational related optimal growth (GAP/GROW) training.

Staff told us they completed skills and drills in pool evacuation. Maternity staff had received a waterbirth study day by an external midwife. Data for August 2023 showed the training compliance was 88%.

Managers and staff told us that they did not always give staff time away from clinical duties to complete training due to staffing pressures.

Safeguarding

Maternity

Staff told us that they understood how to protect women and birthing people from abuse and gave us examples of when the service had worked well with other agencies to do so. However not all staff had completed training updates, putting women, birthing people and babies at risk of harm.

Safeguarding training updates were delivered by the safeguarding specialist midwife and covered the expected modules for safeguarding level 3 training including how to recognise and report abuse.

Midwives completed safeguarding training alongside social care staff to improve interagency communication and collaborative working. However not all maternity and medical staff had completed level 3 adult and children's safeguarding training. Data showed 68% of obstetric consultants had completed level 3 adult safeguarding training and 84% had completed level 3 children's safeguarding which was below the target of 85%.

There was no safeguarding training data submitted for junior doctors for either adult or children's level 3 training and no data provided for registrars for children. However, 45% of registrars had attended level 3 adults safeguarding training, which was below the target of 85%.

However, staff told us that they knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff told us that they knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could contact when they had concerns. Care records we looked at detailed where safeguarding concerns had been escalated in line with local procedures. There was a safeguarding flow chart and there was a referral process which detailed contacts for the safeguarding team and the local authority safeguarding teams.

Mental Capacity Act training data showed 65.7% of maternity and medical staff had completed this training. Obstetricians and midwives as part of their induction period and their mandatory training had to complete the perinatal mental health e learning training. The training included maternal health disorders, risk assessment and referral routes.

The service safeguarding team worked in partnership with a local mental health service to provide a booking in midwifery assessment service to all pregnant women and birthing people admitted for drug and alcohol detoxification.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. The service had guidance on how to support women and birthing people with a learning disability, a flag was placed on the electronic notes system.

The service had an in-date baby abduction policy. Staff we spoke to had not completed any recent abduction drills; however, were aware of the abduction flow chart which guided what staff should do. The senior team advised of two security drills completed in 2023. The service confirmed the child abduction plan was reviewed and updated in line with lessons identified from exercises.

Cleanliness, infection control and hygiene

Maternity

The service did not always control infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They mostly kept equipment and the premises visibly clean however there were no established cleaning schedules for staff to use daily.

Maternity service areas were visibly clean and maintained and had suitable furnishings. However, during our inspection, we did not see cleaning schedules and staff told us that cleaning check lists were not provided for completion such as for the birthing pool. Some staff had developed and completed their own cleaning check lists. Staff told us that they cleaned equipment after contact with women. However, during the inspection we could not see 'I am clean' stickers to identify when equipment was cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service.

Following the inspection, the service provided data to show there were monthly cleaning audits completed in all areas. From May 2023 to July 2023 audits showed cleaning compliance in all areas was between 97.36 to 97.6%.

The service had a star rating escalation system for cleaning audits, with 5 meaning the area had achieved its target score. Scoring 3 meant the area was automatically under review and an improvement plan developed.

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

Data provided by the service showed maternity staff were not compliant with the service target in infection, prevention and control (IPC) training. Maternity and medical staff were below the 90% target at 83.6%.

The maternity unit collected hand hygiene data which was entered onto the saving lives web-based systems. Matrons undertook checks on their wards and fed back information to their own divisions. However, data received from the service showed continued low compliance in hand hygiene. The most recent audit was July 2023 which showed areas of low compliance with 50% hand hygiene compliance in the delivery suite, 50% in the antenatal unit and 60% in the postnatal unit against a target of 95%.

The delivery suite and postnatal care ward had not achieved the target in April, May and July 2023 in the following areas: urinary catheter care, urinary ongoing care, peripheral line insertion and peripheral line continuing care.

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 limited availability of a second theatre and there was no second obstetric theatre available overnight impacting on the safety of women, birthing people and babies.

The design of the environment followed national guidance with a main entrance and out of hours access to triage via the Women and Children's emergency entrance. Antenatal care was provided in one area and postnatal and transitional care

were on the same ward. Transitional care provides support for women and birthing people and babies born at 34-37 weeks gestation or babies born small for gestational age and not requiring neonatal unit care but requiring additional support. Inductions of labour took place on the antenatal ward and there was a separate transitional care area within the postnatal ward.

The birth partners of women and birthing people were supported to attend the birth and provide support. The maternity unit was secure and there was a monitored entry system. The service had suitable facilities to meet the needs of women and birthing people's families. For example, all rooms had an individual ensuite, spacious and light affording privacy and dignity and an accessible environment. There was access to birthing pools, birth balls and stools to support movement in labour. Inductions of labour took place on the antenatal ward and there was a separate transitional care area within the postnatal ward.

However, there were ongoing recurrent delays in emergency caesarean section (LSCS) births due to a lack of a second theatre overnight.

The postnatal ward had a risk assessment to protect patients from self-harm and suicidal ideation using ligature points. Staff completed individual risk assessments for women and birthing people. The assessment included ligature checklist and a safety plan. Ligature point risk assessments had been completed for each area of the maternity services and each item of risk was identified and a risk score agreed, along with control measures.

A quiet room was selected for delivery of those suffering the loss of their baby. The service had a large self-contained bereavement suite away from the clinical areas which included an entrance hallway, kitchen diner and a double room with ensuite facilities.

There was a feeding room which had a milk fridge specifically for infant milk storage. The fridge had a key code and was accessible only to maternity staff. The name, hospital number, date and time expressed were written clearly on all labels. The milk-fridge was checked daily to ensure it was always locked and maintained at the correct temperature for safe storage. However, during the inspection we saw a woman’s partner access the fridge using the secure code. We spoke to staff and were told this was not usual practice and only maternity staff should have access to the infant milk fridge.

Staff told us that they had two maternity theatres and two high dependency beds for women and birthing people requiring a higher level of monitoring after delivery. Women and birthing people could reach call bells and staff responded quickly when called.

The service had enough suitable equipment to help them to safely care for women, birthing people and their babies. For example, in the maternity unit there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Staff told us that they had sufficient CTG machines. Staff carried out daily safety checks of specialist equipment. Managers did not review compliance with completion of daily checks and audits.

All medical devices looked at on inspection were in date for servicing. The service had a system to monitor equipment safety checks and a register which showed all medical equipment and identified items that required servicing or replacing. Staff disposed of clinical waste safely and sharps bins were labelled correctly.

Safety checks of the emergency equipment were meant to be carried out daily. However, equipment checking sheets showed that not all emergency trolleys and equipment were checked daily. There were 6 days in July and 10 days in August 2023 when the equipment was not checked. Further review of equipment checking data showed gaps in January 2023 – May 2023.

All equipment and store cupboards were visibly clean, tidy and uncluttered in a locked room however the tall storage cupboards were not locked units on the antenatal and postnatal ward.

Assessing and responding to risk

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

There was a separate risk assessment on admission to antenatal ward for women and birthing people being admitted for inductions of labour (IOL) however we reviewed evidence of inductions of labours having been delayed without further ongoing risk assessments.

The service reported during the period of 1 January 2023 – 31July 2023 there were 941 delayed inductions of labours. Delays ranged between 54 hours – 92 hours.

Staff reported there were a high number of delays for inductions of labour due to staffing and acuity on the delivery suite and medical staff were not always available to undertake reviews. Staff told us that those needing IOL were allocated to the delivery suite based on how long they had been waiting. However, managers told us that the level of risk was also considered when transferring to the delivery suite, although this was unclear from discussions with staff.

Following inspection, the service informed us delays to IOL were on the risk register and detailed the procedures for safety huddles and escalation to senior leaders. A proforma had been introduced to list the women and birthing people who were wating for IOL. A 2020 report to the board documented why the service was not following National Institute for Care and Excellence (NICE) guidelines and we were told a further IOL service policy/guideline was under review for implementation in October 2023.

Information from incidents and service reports showed that over the past 12 months there were ongoing recurrent delays in emergency caesarean section (LSCS) births due to a lack of a second theatre overnight, lack of theatre availability due to use, lack of theatre staff, over running elective caesarean sections list. This meant an increased risk of harm, including cases reported by the service such as babies with “acute fetal hypoxia”, had emerged due to delayed births. Data showed that 42% of category 1 emergency LSCS April 2023 – July 2023 were delayed and 29% of category 2 emergency LSCS April 2023 – July 2023. Following inspection, the service informed us of a change of process for use of the second theatre to reduce delays.

Information provided showed that in July 2023 the rates of postpartum haemorrhage (PPH) where above 1500mls were higher than the national average. The service reported the PPH major obstetric haemorrhage rates as 37 in April and 33 in July 2023 which was above the national rate of 31.

Maternity

The service had reviewed all cases of PPH rates above 1500mls and information showed the service was estimating blood loss rather than measuring blood loss. Following the review, the service recorded all PPH above 1500mls major obstetric haemorrhage as an incident, any spikes in cases were reviewed at the multidisciplinary risk meeting with themes and learning shared with staff.

Following inspection, the service confirmed the current out of date guidance for staff on managing post-partum haemorrhage (PPH) remained in use, with a new version drafted to be ratified on 20 November 2023. We were told all PPH incidents had been reviewed by a multidisciplinary team with face-to-face discussion and examination of medical records. Also, we were told there would be improvement to PROMPT training because of findings.

The service confirmed there had been a spike of 3rd degree tears in August which they had reviewed and were not found to be linked to one cause. They had identified some themes such as the length of time women and birthing people were in the second stage of labour and would continue to be considered as part of planned master classes.

The regional maternity dashboard enabled maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The maternity quality dashboard reported on clinical outcomes such as the level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. However, the maternity dashboard shared with the inspection team did not show how the service benchmarked all data against regional or national data and it was not clear as to whether the service was meeting their current target.

Maternity triage at the time of inspection had a matron as midwifery lead, but no manager or coordinator. We were told the antenatal ward manager was supporting the matron for triage for staff management issues. There was an obstetric lead consultant as well as another consultant leading on the quality improvement work to introduce the prioritisation tool implementation.

Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. There were core midwives working within triage and the day assessment unit.

The service had a maternity triage standard operational procedure (SOP). The SOP was in date and reviewed by the maternity risk review group. The senior leadership team told us they had trained staff and created a guideline to be used on the triage assessment tool. This had not commenced at the time of inspection. We found the maternity triage did not have a standardised tool to complete risk assessments for women and birthing people on arrival. Midwives used their clinical judgement to assess and triage women.

Data provided showed in May 2023 there were 942 women and birthing people attending triage with 303 having a doctor review. Out of these contacts, 89% of women and birthing people were seen within 30 minutes, the average waiting time to see a midwife was 52 minutes and the average waiting time to be seen by a doctor was 42 minutes. In June 2023 there were 930 women and birthing people attending triage with 299 having a doctor review. The average time to see a midwife was 63 minutes, 40 minutes to see a doctor and 79% of women and birthing people were seen within 30 minutes. The service was not following a policy led timeframe to ensure who would have the most urgent assessment.

A handover of care onsite guideline was in place for staff and a situation, background, assessment and recommendation (SBAR) tool was used by maternity staff when handing over the care of women, birthing people and babies to others. Newborn babies classed as a high risk were monitored using a newborn early warning trigger and track chart (NEWTT). Newborn infants that triggered on the chart were referred and escalated for paediatric review and management.

Maternity

The SBAR audit and the Newborn early warning trigger and track (NEWTT) audit were not currently on the clinical audit programme, however it was planned to incorporate the audits into the quality assurance programme.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people.

The service monitored compliance of MEOWS through audits. These audits were incorporated into the maternity services sepsis audit. Data received from an audit completed from June 2021 to August 2022 showed there was a lack of following guidelines and undertaking the sepsis bundle, a delay in administering antibiotics and an uncertainty of diagnosis of sepsis. There was insufficient monitoring, documentation and follow up. There were 7 actions on the audit to be completed by July 2023. We were told the maternal sepsis audit was currently being re-audited and MEOWS would be audited as a standalone audit from October 2023.

Cardiotocography (CTG) cases were reviewed at the weekly multidisciplinary (MDT) training sessions and during investigations of reported incidents. The fetal surveillance team were developing the CTG audit programme to show staff compliance with CTG guidance.

The service completed monthly cardiotocography (CTG) and ‘fresh eyes’ audits. CTG is used during pregnancy to monitor fetal heart rate and uterine contractions and CTG interpretations is used as a part of a holistic review. It is best practice to have a “fresh eyes” or buddy approach for regular review of CTGs during labour. We saw evidence of cases where there was incorrect interpretation of CTGs in the triage area, with CTGs having not been reviewed by a senior doctor or escalated. Although the senior clinical team could have reviewed the CTG through remote central monitoring.

The CTG and fresh eyes audit for October 2022 to April 2023 showed compliance with hourly CTG reviews had declined to 80% and compliance with hourly 'fresh eyes' reviews had increased to 83%. However, this was below the target of 85% compliance. The service had an action plan to address low compliance and planned to continue quarterly audits to monitor improvement.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists every month. Data showed from May 2023 to August 2023 the service was 92% compliant which met the service target.

The NHS Digital national maternity dashboard reported women and birthing people smoking at delivery as 8.2, compared to the national figures of 7.9. The service has not provided data relating to smoking cessation.

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

There were a range of consultant led clinics for women and birthing people with higher risks such as with diabetes and other conditions. Fetal medicine clinics were provided in collaboration with the regional Fetal medicine centre. There was a consultant led service for anaesthetic review of women during the antenatal period. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Maternity

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

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all key information to keep women and birthing people and babies safe was shared using the SBAR format. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

The service provided transitional care for babies who required additional care.

Staff completed risk assessments prior to discharging women and birthing people into the community and ensured third-party organisations were informed of the discharge.

Midwifery Staffing

The service has had issues with the recruitment, retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk. However, bank and agency midwives were used to mitigate the risks.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. Twelve midwives had left the service in the 6 months before the inspection. Staff told us sickness rates were increasing as staff became more stressed. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. There were 48 bank staff available to the service as well as agency with regular use of each.

Managers calculated and reviewed the number and grade of midwives, maternity support workers needed for each shift in accordance with national guidance. The executive nursing team completed a midwifery staffing review in June 2023, with the previous taking place in December 2022. Since the previous review, the service introduced a retention programme board and associated working groups, a new preceptorship programme and the recruitment of a pastoral care nurse. The service provided a continuation of career café and retention rounds with the recruitment matron and professional standards team.

The service presented a midwifery workforce planning paper at service board in December 2022 that proposed several new maternity roles. The service employed specialist midwives to fulfil the CNST safety actions.

The service was seeking to secure funding to increase the midwifery staffing establishment to match the national staffing acuity tool. The nursing and midwifery workforce plan reported the service aimed to reduce the turnover rate of staff to be in line with the service target of 12%. However, staff told us the turnover rate remained above this target and was 14.2% in June and 14.6% in July 2023. The service reported a deficit of between 2.81 whole time equivalent (WTE) midwives at the 21% uplift and 7.81 (WTE) at 23%. The service informed us after inspection the rates for midwifery staffing in August 2023 had been a vacancy of 7% with a turnover rate at 11% alongside a sickness absence rate at 4.4%.

Maternity

The service rarely reported maternity 'red flag' staffing incidents, including escalations and closures in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. This meant the leaders could not be assured of the safe level of staffing. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Staff told us the service was frequently short staffed, managers also told us that there were times they were short of midwives. We saw evidence from incidents reported where staff shortages had impacted on care.

Managers calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift without current acuity tool recommendations.

There was a supernumerary shift co-ordinator on duty 24/7 who had oversight of the staffing, acuity and capacity, however there were reported incidents of when the co-ordinator had not maintained this supernumerary status.

The ward manager did not always have the resources to adjust daily staffing levels according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice, and they were expected to work in areas unfamiliar to them.

The service showed us a regional escalation policy and supplied a local escalation policy following inspection; however, we did not see evidence of this having been used by staff.

Managers did not always make sure that staff received any specialist training for their role, however there was a matron development programme underway to develop band 7 midwives.

There were statistically significant differences between white staff and staff from ethnic minority groups for 2 Workforce Race Equality Standard (WRES) indicators, suggesting poorer experiences for staff from ethnic minority groups.

There were statistically significant differences between staff with long term conditions and staff without long term conditions, for several WDES Workforce Disability Equality Standards indicators (WDES), suggesting poorer experiences for staff with long term conditions.

Managers did not always complete staff appraisals and work performance or hold supervision meetings with maternity staff to provide support and development. The service policy was for all staff to have annual appraisals. The service report for the 12 months prior to September 2023 showed that 76.6% of midwives, 33.3% midwifery managers and 81.8% midwifery specialist practitioners had received an appraisal.

The service had professional midwifery advocates available to support midwives and staff, in addition to their managers. Midwives and managers told us they had the opportunity to attend supervision sessions.

Medical staffing

The service had enough medical staff to keep women and birthing people and babies safe, however medical staff did not always have the training and supervision to update skills to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends, staff told us and incidents reviewed showed us at times there had been a reluctance for consultants to attend when called out of hours however some staff told us they felt this situation had improved over recent months. The service clarified that an obstetric consultant attendance audit had been completed earlier in the year which demonstrated attendance of the on-call consultant as required.

Information provided did not include consultants and medical staff due to the structure of the healthcare appraisal and job planning system. However, the service told us that there was a rolling programme for this staff group to complete appraisals during the current year. Trainee medical staff completed an annual review of competency progression process which included training and appraisals.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The service used a combination of paper and electronic records. We reviewed 6 paper records and found records were clear and complete.

Maternity records were monitored through case reviews and learning shared with maternity teams. Staff completed documentation audits. However, the service did not collate this information and there was no process to provide oversight of records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Medicines

Staff did not always follow systems and processes to prescribe and administer medicines safely. However, medicines were not always kept secure and although controlled drugs were checked these checks did not include recording the actual numbers of drugs and not all signatures were recorded, or legible within the controlled drugs record books.

The service had systems to check staff competency when using medicines was in line with service policy and national guidelines.

Senior pharmacists and pharmacy technicians were responsible for the delivery of the Medicines Management and Medication Safety Training. Training was face to face classroom training.

Medicines training was delivered as part of the induction programme for clinical staff. There was a clear process for medicines training for each staff group.

Midwives completed a medicines assessment and an IV therapy passport programme and all staff completed an assessment book.

There were lockable controlled drugs cupboards, each with an inner locked cupboard where controlled drugs were stored. The controlled drugs book for recording volumes stored and administration was incomplete and there had not been a controlled drug audit.

Staff signatures were not always recorded in the controlled drugs record books and some signatures were not clear and legible. Some of the required relevant information was missing. For example, we saw an omission of the administering persons signature from the record.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Medicines were not always kept securely in medicine cupboards especially in Labour ward, to be assured of limiting the volume held and unnecessary access. Although stored in a locked room we found some medicines in open cupboards and drawers.

Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Woman and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Incidents

Staff did not always complete incidents and when they reported incidents managers, did not always investigate them. When things went wrong, staff did not always apologise and therefore did not always give women and birthing people honest information and suitable support. There was not always enough learning by the service from incidents to prevent repeated occurrence and harm.

Staff told us they knew what incidents to report and how to report them but did not alway1 s report concerns or complete incidents reports and near misses in line with service policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. However, evidence reviewed showed that this did not always happen and at times incidents were reported weeks later retrospectively delaying identification of any learning.

Managers did not always investigate incidents thoroughly, recording "known complication" in these investigations. We reviewed 12 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In 7 investigations, case managers shared duty of candour and draft reports with the families for comment.

Between 1 September 2022 – 1 August 2023 320 incidents were reported as no harm, 22 reported as low harm, 8 as moderate harm and 2 as severe harm.

Maternity

Of the 320 incidents reported as no harm, 100 (31%) of them were postpartum haemorrhages (PPH), 10 of the 22 low harm incidents were PPH (45%) and 3 of the 8 moderate cases (38%) were PPH. In total 32% of the incidents reported were PPH's, the service told us they did not review cases of low harm or no harm, which is not in line with national Royal College of Obstetricians (RCOG) Green top 52 PPH Guidance. This means the service may be missing opportunities to learn from incidents and make potential improvements to prevent further PPHs.

We found cases of low harm and moderate harm to be reported as a reduced level of harm and multiple incidents reported as no harm were inaccurately graded at this lowest level.

In the last 6 months, 7 incidents had been referred to the former Healthcare Safety Investigation Branch (HSIB) for investigation. We reviewed perinatal mortality review summary report August 2022 to July 2023, which identified the causes of neonatal deaths, contributory factors and actions. The service reported recurrent themes following the perinatal mortality reviews as scans not completed as indicated, small babies not identified during pregnancy and there were cases where the care was not managed appropriately in line with local and national guidance including lack of one-to-one care in labour and care plans had not always been followed.

We saw and staff told us there was a lack of reporting incidents related to staff shortages, one-to-one care, escalation for senior medical support and for occasions of consideration of unit closures, delays to elective care and the co-ordinator supernumerary status through the incident reporting system.

The service had one never event recorded from December 2022 regarding retained gauze swabs. However, our review shows there should have been 3 listed as a Never event. Information from the service showed ongoing compliance issues and the swab count policy was at the top risk of the maternity service risk register.

Never events are events that the NHS define as an incident that "should not occur if the available preventative measures had been implemented".

We were told a serious incident review panel met within 48 hours to decide if any incident was a serious incident. The maternity teams completed a 72-hour report to ensure immediate learning and safety actions were captured and shared.

Incidents or risks requiring a multidisciplinary review were discussed at the weekly risk meeting. Learning from incidents was distributed to the maternity team via emails, newsletters and the service's internal communication 'getting learning out weekly' (GLOW) message. Patient safety incidents reported were reviewed and triaged daily by the Patient Safety Team and in the weekly multidisciplinary risk review meeting. Incidents were discussed at the midwifery safety huddle at 10am daily. Any incidents requiring urgent action were escalated at this meeting. Incident themes and trends where gathered, were reported in the monthly governance report which was presented by the risk and governance manager at the monthly clinical governance meetings.

Staff did not always show understanding of the principles of duty of candour as they were not open and transparent about all incidents therefore did not always give women and birthing people and families a full explanation when things went wrong.

Maternity

The service had a ‘learning from incidents’ midwife who was responsible for sharing learning from incidents with staff. For example, the service reported the outcomes from some serious incident reviews and shared learning from the obstetric clinical governance meeting to the trust board in a maternity services paper July 2023. The paper described how leaders reminded staff of the importance of ensuring good communications and explanations in both planned deliveries and when declaring the urgency of an emergency instrumental delivery.

There was limited evidence that changes had been made following incidents however staff explained and gave examples of additional training implemented following a medication incident.

Managers said they debriefed and supported staff after any serious incident.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Local leaders supported staff to develop their skills and take on more senior roles. However, they were not always visible and approachable. Senior leaders did not always understand and manage the priorities and issues the service faced.

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

The director of maternity was a recent internal promotion, we were told this was after a year of changes and uncertainty. The director or midwifery during the inspection told us of the challenges to quality and sustainability within the service.

The head of midwifery role was vacant at the time of inspection. The acting head of midwifery, consultant midwife and matrons were under the director of midwifery’s leadership. The interim head of midwifery line managed the matron for maternity transformation and interim matron for safety and governance.

The service was supported by maternity safety champions and non-executive directors. Maternity safety champions carried out regular visits and walk rounds at The Tunbridge Wells Hospital at Pembury. The executive team visited wards on a regular basis. However, staff told us senior midwifery leaders were not always visible and approachable in the service. Staff told us they were mostly supported by their line managers, ward managers and matrons. Some staff felt that communication could have been shared better by senior leaders.

Staff told us they felt supported to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help them progress.

Vision and Strategy

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to implement them and monitor progress.

The service's organisational vision was Exceptional People, Outstanding Care (EPOC). All improvement activity including projects, activities and goals were aligned to the strategy. The service used their EPOC improvement programme to provide a structured approach to support delivery of their vision.

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

The service wanted to promote collaborative service provision through working with women and birthing people to promote patient centred care.

The service was in the process of developing a Nursing, Midwifery and Health Care Support Workers strategy, this strategy will be used to inform and update the Maternity Strategy which will incorporate a multidisciplinary approach.

Culture

Staff felt respected, supported and valued. However, there was a need to ensure the service promoted equality and diversity for staff and to ensure an open culture. A culture where women and birthing people, their families and staff could raise concerns without fear.

Staff were mostly positive about working in the service and its leadership team. Staff felt able to speak to leaders about difficult issues and when things went wrong. The staff experience survey was completed quarterly and results from the July 2023 survey were lower than previous years.

In response to feedback given directly to the chief of service, chief nurse and maternity safety champions, listening events were developed and supported by the wellbeing team.

The service developed a matron development programme which was supported by the organisation development team, along with developing and implementing a senior leadership training matrix for band 7 midwives and upwards.

The service had a rolling action log to document staff concerns. Examples of concerns raised were maternity areas being short staffed, lack of medical cover in triage and preceptors being moved whilst supernumerary to cover staffing gaps on the delivery suite. As a result of concerns raised the quality improvement project on triage included a review of medical and midwifery staffing and work patterns.

The rolling log action log showed actions taken such as CTG machines had been ordered and staffing levels monitored during the daily safety huddle. However, for some concerns no action had been taken due to staffing issues and being able to continue with one-to-one care.

Maternity

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

The service had an open culture where women and birthing people and their families could raise concerns without fear. Women and birthing people, relatives and carers knew how to complain or raise concerns. There had been 9 complaints about the care received at The Tunbridge Wells Hospital at Pembury between May and August 2023.

All complaints and concerns were handled fairly and the service used the most informal approach that was applicable to deal with complaints. The service gave information about how to raise a concern in welcome packs in each birthing room. Staff understood the policy on complaints and knew how to manage and respond to them.

Governance

Leaders did not operate effective governance processes throughout the service. Staff were not always clear about their roles and accountabilities and they did not have regular opportunities to meet, discuss and learn from the performance of the service. The service leaders did not always assess, monitor or improve the service through effective audits and mitigate risks.

The service had a developing governance structure, managers told us they supported the flow of information from frontline staff to senior managers. The interim head of midwifery was the lead for governance within the midwifery service.

Structures for maternity services, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were not clearly set out, understood and effective. There was however a maternity and gynaecology - clinical risk management and safety strategy for women's services.

The service supported the flow of information from frontline staff to senior managers through women's services clinical governance meetings. Maternity service performance reports were shared within the women's, children's and sexual health divisional monthly board meetings. Staff knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

However, leaders did not monitor key safety and performance metrics well. We found the service did not always complete a clear auditing schedule and not all incidents reported were investigated or audited. For example, the use of maternity early warning scores, or reviewing incidents including delays in induction of labour, delays in emergency caesarean sections or major post-partum haemorrhage (PPH).

Whilst on inspection we spoke with senior leaders about the high PPH rates and contacted the service post inspection to seek further assurance. We found senior leaders did not have action plans to reduce PPH rates although they were aware that the PPH rate was higher than the national rate. Data from July 2022 – June 2023 on the maternity service dashboard showed the PPH rate was above the national average for 10 months and was on an upward trend.

The service had 5716 births for the rolling year and the 2021 NHS Survey reported the service maternity user groups were 89% white, with 10% other ethnicity. The service had limited monitoring of outcomes data for improving health inequalities.

There was a lack of monitoring of the incidence of bladder trauma risk, failed trial without catheter (TWOC) and surgical injuries. We found there were 5 bladder injury incidents for the period 1 January 2023 -1 May 2023. The service reported these incidents as low harm “where minimum harm has been caused” however, the narrative provided by the service was, “short term harm caused” therefore it would have been appropriate to report them as moderate harm. These examples meant there were missed governance opportunities by the service to make improvements to safety.

Management of risk, issues and performance

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

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

We saw staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS), for women and birthing people. An audit of compliance of MEOWS was incorporated into the maternity services sepsis audit. An audit, completed in August 2022, found there was a lack of adherence to guidelines, lack of compliance with the use of the sepsis bundle, delays in administering antibiotics, an uncertainty if to diagnose sepsis and insufficient monitoring, documentation and follow up. There were seven actions arising from the audit due to be completed by July 2023. On inspection there was no evidence of completion of these actions. We were told the maternal sepsis audit was currently being re-audited and MEOWS would be audited as a standalone audit from October 2023.

There was a maternity clinical audit programme for current local and national projects; however, managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The service leaders did not always audit performance and could not always identify where improvements were needed. The leadership team were therefore not always responsive when staff identified where improvements could be made and action to make changes was delayed.

We saw a “Handover of Care” guideline which used a Situation, Background, Assessment and Recommendation approach (SBAR). This tool was used by maternity staff when handing over the care of women nd babies to others. However, there had been no audit of compliance with the use of the SBAR tool as per trust guidelines. This meant there were missed opportunities to assess use and understanding of the SBAR approach. The service told us they did not have an SBAR audit, it was not on their clinical audit programme.

Newborn babies classed as a high risk were monitored using a newborn early warning trigger and track chart (NEWTT). Newborn infants that triggered on the chart were referred and escalated for paediatric review and management. The service told us they had not completed a NEWTT audit, and it was not on their clinical audit programme.

Some audits were not currently on the clinical audit programme and the service planned to incorporate these into the quality assurance programme in the future. Without audits the service was unable to provide assurance that the care provided was safe, effective, responsive, appropriate and timely.

Leaders did not always monitor policy review dates. For example, policies and guidance for post-partum haemorrhage, induction (with Propress and Prostin Gel) stimulation and augmentation of labour should have been reviewed in May 2021. Following inspection, the service told us these would be updated in October 2023 and November 2023 respectively. This meant there was a risk that staff were not always working in line with the most up to date guidance.

.

There was a service wide risk register. There were 12 entries on the risk register going back to 2018 one of which was for recovery nurses with a review date of 29 August 2023. Other topics included delays for induction of labour, communication about consent, lack of following of processes and guidelines for fetal monitoring and swab count procedures. There had been an impact of a legionella risk on the maternity service which was being addressed at service level as part of partnership working with the PFI provider of the building.

There were plans to cope with unexpected events. They had a detailed local business continuity plan. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

The service did not always collect 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 service did not always collect reliable data and analyse it**.** The monthly maternity dashboard, accessible to all senior manager, we reviewed did not display the key performance indicators for the service. We could not see how the service benchmarked against regional and national data for comparison.

The information systems were integrated and secure**.** The service had 2 digital midwife roles to support staff accessing electronic information systems.

Data was collected 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.

Engagement

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

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

The MNVP were focused on seeking out and hearing from women and birthing people's feedback to develop and improve services through co-production with women, birthing people and their families.

The service was working with the MNVP and LMNS to develop the MNVP service in line with the Clinical Negligence Scheme for Trusts (CNST) and introduce face to face quarterly co production clinics.

Maternity

The MNVP had attended antenatal and postnatal wards at the hospital to speak with women, birthing people and their families and staff. Not all staff were aware of the MNVP and their role and joint working had been limited. We were told this was now improving through regular monthly meetings with the MNVP and new senior leadership team.

The service was working with the MNVP on co-production projects in antenatal education, birth after thoughts, reviewing information provided on discharge and counselling after sonography.

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

There were maternity staff engagement days and maternity matron engagement days. The service had previously completed listening days to gain feedback on the maternity service from maternity and medical staff.

The recruitment and retention lead completed a maternity roster work project with working groups across acute, community and birth centres and managers on call. The working groups reviewed and worked to see how improvements could be made to on call rotas, bank work, rosters and the preceptorship programme. Maternity staff were asked to complete a roster survey and the results were disseminated to staff.

Leaders did not always understand the needs of the local population. We were told there was gap in the services available for women and birthing people from different ethnicities and social economic backgrounds. The service provided limited antenatal education with online courses on the trust website. Staff also delivered antenatal education around infant feeding via monthly virtual sessions. Women and birthing people could not access support unless paying for the service privately.

The CQC Maternity Survey results for 2022 showed, in comparison to other services Maidstone and Tunbridge Wells NHS Service scored 'better' when compared to other services in terms of cleanliness. Labour and birth when compared with other services was 'about the same' regarding information on induction, advice on risks of induction, decision to be induced, advice at the start of labour and partner involvement.

The 2022 General Medical Council National Trainee Survey (GMC NTS) showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

Learning, continuous improvement and innovation

Staff told us they were committed to learning and improving services. However, staff did not always have the resources to implement improvements to the service; there were delays or a lack of evidence of improvements being implemented.

The service was not always committed to improving services by learning when things went well or not so well. For example, maternity and medical staff were below the service target for mandatory training, skills training and appraisals.

Quality improvement was routinely discussed at team meetings and within directorate newsletters and senior leaders attended the monthly service quality improvement committee meeting.

Maternity

We reviewed three sets of quality improvement committee meeting minutes and saw the July 2023 minutes highlighted work being completed within the maternity service. We were provided with a project update for current projects which outlined the aims and current progress. The information in the current project documents corresponded to the issues raised within the quality improvement committee including maternity staff not completing the swab count checklists and the lack of assurance women and birthing people were being seen within appropriate timeframes when attending triage.

Following local risk incidents and national recommendations, it had been agreed that maternity services would embed a standardised triage assessment tool to facilitate timely assessments of women and birthing people presenting to maternity triage.

There was a clear interest in research and the services were winners of a National Institute for Health and Care Research award for their contribution to research projects across the region. This was in relation to a research trial for the routine testing of pregnant women for group B Strep (GBS), the most common cause of life-threatening infection in newborn babies in the UK, comparing two different testing approaches. The teams' research led to 80% of eligible women being offered the test for group B Strep.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 service MUST take to improve:

Maternity

- The service must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and any deterioration escalated. (Regulation 12 (a) (b)).
- The service must ensure staff complete all mandatory training, including safeguarding training as well as role specific training modules such as CTG training and are competent in carrying out CTGs. (Regulation 12 (1) (a) (2) (a) (b) (c) (e)).
- The service must ensure that staff have carried out daily safety checks of emergency and specialist equipment. (Regulation 15 (1) (e)).
- The service must ensure systems and processes for maternity triage are reviewed to deliver a safe service in line with national guidance. (Regulation 17 (2) (a) (b) (c)).
- The service must ensure there are effective governance systems and processes to identify and manage incidents, risks, issues and performance and to monitor progress through completion of audits, action plans and oversight of improvements and reduce the recurrence of incidents and harm. (Regulation 17 (1) (2) (a) (b) (e) (f)).
- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people and babies. (Regulation 18 (1)).

Action the service SHOULD take to improve:

Maternity

- The service should ensure the vision and values relate to the current model of maternity care and all staff understand and apply them to their work.
- The service should ensure staff complete abduction drills and are confident in the process to follow.
- The service should ensure all cleaning schedules and check lists are developed and completed to meet the needs of the service.
- The service should ensure all medicines are stored and managed safely.

Following our inspection, we served a warning notice asking the trust to make significant improvements on timely action of emergency caesarean births, risk management, and governance and oversight of the service. The service was required to submit an action plan, and we will continue to monitor progress in relation to this.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC senior specialist, two midwifery and one obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.