Maidstone and Tunbridge Wells NHS Trust

Crowborough Birthing Centre

Inspection report

Crowborough War Memorial Hospital
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Crowborough
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Ratings

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

Our findings

Overall summary of services at Crowborough Birthing Centre

Requires Improvement

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

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

The Crowborough Birthing Service provides maternity services to the population of Crowborough.

Between November 2022 October 2023, 154 babies were born at Crowborough Birthing Centre.

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

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

Crowborough Birthing Centre was not previously inspected under Maidstone and Tunbridge Wells NHS Trust.

Our rating of this hospital is rated as Requires Improvement. We rated safe as requires improvement and well-led as requires improvement.

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

Our reports are here:

Maidstone Birthing Centre – https://www.cqc.org.uk/location/RWF03

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

How we carried out the inspection

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

We visited the midwifery led birthing centre.

We spoke with 3 midwives, 2 maternity support workers, 1 domestic worker, 1 volunteer and 1 service user. There was 1 woman admitted into the birthing centre during the inspection.

We reviewed 5 patient care records.

Our findings

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

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

Maternity

Requires Improvement

We rated it as requires improvement because:

- Not all staff had training updates in key mandatory skills including neonatal life support, safeguarding and competency-based assessments on the use of cardiotocography.
- A review of records showed that the maternity service did not always document whether women were risk assessed as either high or low risk at booking appointment.
- The service did not always have enough staff to make sure women and birthing people were safe.
- The maternity service governance processes and information systems did not fully identify and manage incidents, risks, and performance to reduce the recurrence of incidents and harm.
- There was a lack of clinical audit to check any improvement needed had been achieved.

However:

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

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

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

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

The trust told us the target for mandatory training compliance was 85%.

The service was well below the trust compliance target for basic life support, with midwives 57.1% and health care assistants 50% compliant.

Maternity

During our inspection we spoke with midwives who told us the service had recently gained funding to complete the neonatal life support training. Information reviewed on inspection showed two midwives had been recently funded for the course. Despite this, the core competency data received from the trust showed the overall compliance for neonatal life support was 93%. It was not clear how the trust has arrived at this figure. Neonatal life support training is an important aspect of multi-professional training for clinical staff.

National guidance required all clinical staff working on maternity to take part in simulated obstetric skills and drills training. Training was reported to be delivered by a multidisciplinary team which included obstetricians, anesthetists, neonatologists, fetal wellbeing and fetal surveillance midwives, clinical skills facilitators, specialist lead midwives and obstetricians. The service was 64.3% compliant in PROMPT (obstetric emergency multidisciplinary training).

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

The trust's corporate induction included medicines management. Maternity staff at Crowborough Birthing Centre were 100% compliant.

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

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

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

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

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

Maternity

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

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The level of safeguarding training reflected the trust's policy and the intercollegiate guidelines. Training records showed that staff had 100% Level 3 safeguarding adults training and 92.9% safeguarding children Level 3 training.

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

Staff told us how they identify adults and children at risk of, or suffering, significant harm and how they worked with other agencies to protect them. Staff told us women and birthing people were asked about domestic abuse at booking and at each contact and we saw evidence of women and birthing people being asked about domestic abuse in the patient records at each antenatal appointment.

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

Mental Capacity Act training data showed only 78.6% of staff at Crowborough Birthing Centre had completed training. This did not meet the trust training compliance of 85%. Midwives completed the perinatal mental health e-learning training as part of their induction period and their mandatory training. The training included maternal health disorders, risk assessment and referral routes.

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

Maternity

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

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

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

Cleanliness, infection control and hygiene

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

The Crowborough Birthing Centre was visibly clean and had suitable furnishings which were clean and well-maintained.

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

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

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

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

The service provided monthly clinic audit for Crowborough Birthing centre. From August 2023 to November 2023 the service had an average compliance of between 98.9% to 100%.

Data provided by the service showed maternity staff were 78.6% compliant with the infection prevention and control (IPC) training, which was below the trust mandatory training compliance of 85%.

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.

Maternity

Crowborough Birthing Centre was situated within a community hospital which was under a different NHS trust. Crowborough Birthing Centre has been under the trust since 2016 and was specifically designed as a birth centre to meet the needs of women and birthing people.

The birthing centre had two birthing rooms and three postnatal rooms, two of which had double beds. All postnatal rooms were large, nicely decorated and well maintained with a next-to-me cot for baby. Birthing rooms had adjustable ambient lighting and equipment to play music.

The entrance to Crowborough Birthing Centre was secure with a buzz-in system and intercom to gain access. People leaving the birthing centre needed to be swiped out by staff only.

The service had suitable facilities to meet the needs of women and birthing people and their families. The birth partners of women and birthing people were supported to attend the birth and provide support and there were no restrictions on the number of birth partners allowed.

Partners could stay overnight, and siblings were able to spend time and visit. There were facilities for women and birthing people and their partners. This included a recently updated kitchen, and an area where women could relax and eat their meals. The centre also had free car parking spaces.

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

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

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

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

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

There was a spreadsheet to tick if the emergency equipment had been checked. This was completed daily. However, there was not a system in place to alert staff of out of date or missing equipment or to confirm when resolved.

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

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

Assessing and responding to risk

Maternity

Staff mostly completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

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

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

However, we reviewed 5 maternity care records during the inspection, and it was not always easy to identify whether risk factors for women and birthing people had been assessed at booking. During the factual accuracy process, the service said risk assessments were completed on the electronic record and should be updated at each point of contact antenatally.

Due to the locality of Crowborough Birthing Centre, some women and birthing people within the local area used a neighbouring NHS trust for their initial antenatal booking. A review of incidents showed there had been times when the booking process had failed due to a difference in the electronical booking process used between the two NHS trusts. This meant there were incidences of Crowborough Birthing Centre not being notified of women and birthing people booked into the service and this had led to incidences of missed antenatal and scan appointments.

During the inspection we requested the standard operation procedure (SOP) for Crowborough Birthing Centre. This was not provided during the inspection and staff were unclear of the current guidance used. Following the inspection, we were provided with a copy of the draft SOP for the birthing centre. However, this draft SOP was not in operation during the inspection. The information showed the document had not been ratified and there was information missing. For example, the link to the maternal escalation policy.

Staff were confident and clearly knew the processes for reviewing women and birthing people wanting to attend the birth centre. They were fully aware of the escalation and emergency transfer pathway and could clearly describe the process.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The service had both an antenatal and postnatal situation, background, assessment, and recommendation (SBAR) transfer form in place which detailed information such as times ambulance was called, time of ambulance arrival to the birthing centre and ambulance departure time and arrival time at the destination. However, the birthing centre did not complete regular audits of the SBAR compliance; therefore, the service was unable to identify potential patterns in ambulance delays or potential risks.

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

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

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

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

The birth centre had recently started a monthly meeting for professionals including the consultant midwife to discuss complex or out-of-guidance care that may occur. It was not clear how the information discussed at this meeting was presented to women and birthing people, so they were able to make an informed decision. However, there was an out-of-guidance proforma which detailed potential risks that women and birthing people were asked to sign prior to giving birth at Crowborough Birthing Centre.

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

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared.

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

Midwifery Staffing

Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers mostly regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough midwifery staff to keep women and babies safe. Staff told us they were concerned there was not enough staff to provide safe care and fulfil the staffing model at Crowborough Birthing Centre.

Each day shift was staffed with 1 midwife and 1 maternity support worker. There was no dedicated second midwife allocated to the birth centre, and the service relied on requesting a community midwife to attend as second midwife when there is a woman in labour. Staff told us this often left the community midwifery teams short of staff, and clinics

and home births had to be cancelled at times to accommodate the current staffing process. During the factual accuracy process the service told us during daytime hours, there was a supernumerary band 7 midwife and a retention midwife on duty to assist with births if required. The service also said there was no recorded incidence of cancelled clinics to support births.

Midwives working during the day were mostly band 6 midwives. The birthing centre also provided postnatal care to women, day 5 clinics, breastfeeding support, transcutaneous bilirubinometer (TCB) testing for jaundice, and hypnobirthing. Day 5 clinics also provided metabolic and genetic disorder screening for babies.

Since January 2023, the service had been funded to provide a second midwife at night which meant the unit should be staffed with 2 midwives and 1 maternity support worker. However, when we reviewed staff rota, we found out of the 10 months since the funding had been provided, a second midwife was allocated only 50% of the time in May, 50% of the time in August 2023, and not at all for the remaining months. This equated to having a fully staffed birth centre at night only 10% of the time, which was not safe.

Senior leaders and staff told us community midwives were placed on call to support as a second midwife if required. However, staff were concerned at times there could be a delay dependent on where the midwife was based, which put women and birthing people and babies at risk.

There was a community team lead who provided the overall management for the birthing centre including staffing. The head of midwifery was currently new in post, so the community team lead reported to the director of midwifery.

Rates of turnover and sickness were combined with community teams however, data from September 2023 showed Crowborough Birthing Centre had a 14% vacancy rate.

The service presented a midwifery workforce planning paper at service board in December 2022 that proposed several maternity roles which worked across the maternity sites. The service employed specialist midwives to fulfil the CNST safety actions, such as a mental health midwife, safeguarding midwife, practice development midwives, and risk and governance midwives.

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

Staff told us that all women and birthing people attending the birthing centre were provided with 1:1 care in labour, although the service did not provide data to support this. If the unit were short staffed, shifts were usually covered by a member of the birth centre team during the day. However, at night the second midwife shift was rarely covered.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The appraisal rate for staff was 92.3% for midwives and 100% for maternity support workers.

Records

Maternity

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

We reviewed 5 paper records and found these records were clear, however, they were not always completed in full. For example, in 2 out of the 5 records the woman or birthing person's pregnancy level of risk at booking appointment was not included and there was no additional information about health risks such as comorbidities or high body mass index. This meant that staff did not always have access to relevant information about women and birthing people's health and could not make accurate risk assessments in order to keep them safe.

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

Women and birthing people's notes we reviewed during the inspection were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records, with a plan to transfer all records onto an electronic record system.

The birthing centre had a guide to basic record keeping standards in the birth centre. The guide was clear and detailed the process for intrapartum and postnatal documentation.

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

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines and medicines training was incorporated into the mandatory corporate training for staff.

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

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in a locked cabinet and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation. However, we found the fridge storing solutions for glucose tolerance tests was kept unlocked in the teaching room which women and birthing people and their families had access to.

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 and birthing people honest information and suitable support.

Maternity

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

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

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

There was a daily midwifery safety huddle which was attended by one of the risk team. Learning from incidents was distributed to the team through staff emails, newsletters, and 'GLOW' (getting learning out weekly) messages. Incident themes and trends were presented by the risk and governance manager at the monthly clinical governance meetings.

We had requested from the maternity service all incidents relating to Crowborough Birthing Centre from November 2022 to November 2023. The maternity service provided a document which listed 9 incidents, which were reviewed. We found that 4 of the 9 incidents were related to the electronic recording system and the misinformation and booking of women and birthing people. For example, due to the location of the birthing centre it meant that most women and birthing people attended the local NHS trust for their initial antenatal booking and there was a failure to send booking notifications through to the birthing centre. This meant some women and birthing people had missed scheduled antenatal appointments and scans. Staff we spoke to during the inspection told us that this was a common problem. However, there had been no action put in place to improve the communication between the two NHS trusts.

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

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

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

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, not all staff felt senior leaders were always visible for women and birthing people and staff.

Maternity

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

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

The head of midwifery role had recently been appointed and the service also had a consultant midwife, clinical director and birth centre manager. Below this branch of leadership there was an interim matron for Crowborough Birthing Centre. The birthing centre did not have a ward manager to support with the managerial or clinical work, the interim matron was responsible for managing both the birthing centre and community services.

Executive leadership changes had been challenging for staff and staff we spoke to said leaders were not always visible or approachable in the service for women and birthing people and staff.

Staff did not always feel supported by the senior leadership team and said it felt like there were increased pressures to improve the number of women and birthing people who had their baby at the birthing centre, or there was a risk Crowborough Birthing Centre could close.

Maternity safety champions and non-executive directors supported the service and the maternity safety champions had carried out a recent visit to Crowborough Birthing centre.

Vision and Strategy

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

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

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

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

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

Maternity

Culture

Staff did not always feel respected, supported, or valued by the senior leadership team. Staff were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work.

Staff were positive about working in the service and the support from the birthing centre matron. However, staff felt there was not a consistent staffing model between the maternity services two birthing centres. For example, at Crowborough Birthing Centre a band 6 midwife was rostered alongside a maternity support worker but at the other birthing centre there was always a band 7 and a band 6 rostered alongside 1 maternity support worker.

Staff also spoke of the increasing pressures around the possibility of closure of the Crowborough Birthing Centre if there wasn't an increase in the number of births taking place there.

The service provided information on the NHS staff survey 2022 and staff experience surveys which were undertaken quarterly in 2022 and 2023. However, the results were not broken down into each maternity area. The maternity survey information was also included within the women's directorate which incorporated the results for gynaecology services also.

Following on from the results of the NHS staff 2022 survey there were a number of multi-disciplinary listening events. The service put together a matron development programme and a senior leadership training matrix for band 7 midwives upwards. The maternity safety champions had completed walk the floor visits and the wellbeing team had visited the maternity areas to offer support to staff.

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

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, through monthly team meetings. Staff understood their role within the wider team and took responsibility for their actions.

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

The service had an open culture where women and birthing people and their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. We spoke to one woman during the inspection, who was very happy about the care and support they had been given postnatally at the birthing centre.

There had been 1 complaint about the care received at Crowborough Birthing Centre between November 2022 and August 2023. Staff we spoke to understood the policy on complaints and knew how to manage and respond to them.

Maternity

Governance

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

The service leaders did not always assess, monitor, or improve the service through effective audits or mitigate risks.

Managers told us they supported the flow of information from frontline staff to senior managers. The head of midwifery and interim governance matron led on governance within the maternity service. The service also had a matron for maternity transformation. 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 through the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

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

The service had displayed in the staff area information from the quality and safety assurance update which provided staff with the maternity dashboard for the specific area. For example, the number of babies born, 1 to 1 care in labour, 3rd and 4th degree tears and post-partum haemorrhage (PPH) cases. The service did not audit women and birthing people's records other than to review an incident or complaint. Therefore, the service was unable to gain assurances that all areas of documentation were being completed at each maternity contact. For example, we saw in maternity records that risk assessments were not routinely completed at each maternity contact.

The situation, background, assessment, and recommendation (SBAR) form for emergency transfers was not audited within Crowborough Birthing Centre, therefore the service could not monitor transfer times of women and birthing people and their babies to the obstetric site and therefore could not be assured it was safe.

Staff did not follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance, and leaders did not always monitor policy review dates. For example, we found the following policies were out of date. Criteria for giving birth in the birth centre or at home, review date September 2023 and the maternal transfer guideline, review date October 2023. The Crowborough Birthing Centre's standard operational procedure SOP was in draft format only and staff were unclear of the current SOP used. This meant there was a risk staff were not always working in line with the most up to date guidance and practice.

Management of risk, issues, and performance

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

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

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

Maternity

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

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

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

Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting.

There were 8 entries on the birthing centre risk register from July 2020 to July 2023. The risk register showed from August 2023, the service was not using the current NICE guidance for physiological interpretation. The service was waiting for guidance from the local maternity and neonatal systems (LMNS) to update local guidance to include the new maternal pulse recommendations from the NICE guidance.

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

There were plans to cope with unexpected events. They had a detailed local business continuity plan. From October 2022 to October 2023 the birthing centre had not had any closures for 6 out of the 13 months. The unit had only been open 88.3% in September 2023, but we were told this was due to staff sickness.

Information Management

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

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

The service did not always collect reliable data and analyse it. The service did not have a specific dashboard for the birthing centre, instead data was incorporated into the maternity service dashboard. The service told us during the inspection they would add a separate birthing centre dashboard to the maternity services improvement action plan.

Maternity

The service reported to the local maternity and neonatal systems (LMNS), However, the dashboard we reviewed did not show how the service benchmarked against regional and national data for comparison.

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

Engagement

Leaders and staff actively and openly engaged with woman 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 woman 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 women and birthing people's feedback to develop and improve services through co-production. The service was working with the MNVP and LMNS to develop the MNVP service in line with the Clinical Negligence Scheme for Trusts (CNST) and introduce face to face quarterly co production clinics.

The birthing centre facilitated a weekly drop-in breastfeeding café. The need for further breast-feeding support and the idea for the café came from a maternity support worker within Crowborough Birthing Centre. The idea was supported by senior leaders and the Infant feeding lead and was started in April 2023.

The breastfeeding café gave women and birthing people an opportunity to gain peer support and guidance on breastfeeding whilst being within a relaxed environment and the opportunity to meet other parents. The inspection team observed the café during the inspection, and we saw it was busy and well attended with volunteers providing refreshments. From April 2023 to October 2023 the breastfeeding café had been opened 25 times and 494 women and birthing people had attended with their babies.

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

Learning, continuous improvement and innovation

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

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

Maternity

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

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

Antenatal education and hypnobirthing classes took place at Crowborough Birthing Centre. Community matrons were leading on the project and alongside the MNVP arranged a service user focus group. Staff had volunteered to be involved in the project and were working with the local maternity and neonatal systems team to potentially use virtual antenatal education modules.

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

Areas for improvement

Action the trust MUST take to improve:

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

Action the trust SHOULD take to improve:

- The service should ensure it continues to improve staff compliance to mandatory skills and drills training.
- The service should ensure it completes a simulated baby abduction training to ensure baby safety within the unit.
- The service should ensure they have enough maternity staff deployed to keep women and birthing people safe from harm.
- The service should ensure all fridges containing medicines or solutions should be kept locked and secure.
- The service should ensure all women and birthing people booked into Crowborough Birthing Centre from the local NHS trust are put onto the electronic booking system.
- The service should review incidents related to health inequalities.

Our inspection team

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