William Harvey Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

William Harvey Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The trust has 50 maternity beds across two sites. William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital in Margate, Kent. A total of 6,428 babies were born across the trust during the last year.

The trust is accountable to East Kent Clinical Commissioning Group. Maternity services are provided to a large rural population with small pockets of severe deprivation and has a population that has increased by 21,000 in 2019 due to multiple housing developments across Kent. Since our last report in 2018 maternity services have seen an increasing number of women presenting for pregnancy with complex health needs, who require higher levels of intervention.

The William Harvey maternity unit is run by the Women and Childrens Care Group which provides maternity services across a large area of East Kent. We inspected maternity services at William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. This report presents our findings for our inspection of William Harvey Hospital.

At the time of our inspection, the trust were reviewing maternity and neonatal services after concerns were raised by the Healthcare Safety Investigation Branch, NHS Improvement and the Care Quality Commission (CQC). This was due to a series of historic failures in the care of women and their babies. The last CQC inspection was carried out in August 2018 and rated maternity as requires improvement overall.

Maternity services at William Harvey Hospital include 10 consultant-led labour rooms and eight low risk labour rooms on the Singleton midwifery unit including two rooms with installed birthing pools. There are 28 beds on the Folkestone maternity ward which provides care for antenatal and postnatal admissions. Other maternity services include a fetal medicine unit, a twice weekly consultant led antenatal clinic, a two-bedded day care unit with to additional chair spaces, and a purpose-built bereavement suite. Six community midwifery teams operate across East Kent providing antenatal and postnatal care and a homebirth service. William Harvey Hospital is one of two hospitals in Kent to offer a level 3 neonatal intensive care unit.

Antenatal satellite clinics are available at Kent and Canterbury Hospital in Canterbury, Buckland Hospital in Dover and the Royal Victoria in Folkestone. We did not inspect these clinics as part of this inspection.

There were 3,796 babies born at William Harvey Hospital during the reporting period of January 2019 to January 2020. The trust reported that 178 women opted to have their babies at home.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 22 and 23 January 2020, along with an announced visit to the hospital on the 4th and 5th February 2020.

To get to the heart of women's' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Requires improvement** overall.

- The trust had not achieved compliance with all 10 actions of their safety action plan during the reporting period and two actions remained outstanding.
- On maternity day care, standard operating procedures were not embedded. Risk assessing women was not robust and correct care pathways

Summary of findings

were not always identified quickly, to provide the necessary care and treatment. We highlighted these concerns to the trust, and the care group implemented changes and informed staff.

- Maternity day care admissions and wait times had not been routinely monitored prior to our inspection, which meant staffing did not always meet the needs of the service.
- Leaders used systems to manage performance, however, these were not always effective in all areas of the service. Leaders had not always identified and escalated relevant risks or identified actions to reduce their impact.
- Safeguarding training rates for doctors did not meet the trust target of 85%, only 75% of doctors completed it.
- The service did not always manage infection control well; we found urine specimens unattended in antenatal clinic and day care. Cleaning checks were out of date on some equipment. The trust had two recent cases of Meticillin-resistant Staphylococcus aureus during the reporting period.
- We had concerns about the placement of newborn resuscitaires. The Womens and Childrens care group leads added this to the internal risk register as a tolerated risk which will continue to be monitored.
- Staff in day care did not routinely report all incidents, which meant managers were not always aware of all avoidable events on the unit.
- The service did not always complete incident reviews according to national time frames and their maternity transformation program.
- Antenatal patient records were not always clear, or in chronological order because 50% of records were stored digitally and 50% were hand written. Doctors and midwives used different methods of documentation in women's patient care records. This had also been highlighted in a recent coroner's report.
- On-call consultant and medical cover for maternity and gynaecology was limited. The care group leadership recognised the risk, and at the time of the inspection were taking steps to mitigate this.
- There were times when junior midwives worked alone in day care who did not have the necessary experience, knowledge and skills to escalate complex emergency situations. After our inspection the trust told us that they were reviewing rosters to ensure there was always an experienced midwife on every shift and staff could contact a senior midwifery co-ordinator to escalate concerns.
- Antenatal early warning scores were not being calculated to see whether care and treatment needed to be escalated.
- Pregnant women accessed the waiting area via the main outpatients waiting area where people with long term health conditions waited for appointments. This meant that they may be exposed to health conditions acquired by the non-pregnant population.
- Maternity services did not provide a specialist women-centred, consultant-led perinatal mental health service designed to provide continuity and time for women with mental health conditions in-line with national guidelines.
- The trust's maternity statistics dashboard confirmed the trusts postpartum haemorrhage rate was 5% which is higher than the current national average of 2.7%.
- Midwives caring for women during routine caesarean section did not have sufficient time to support mothers with skin to skin and infant feeding in the first hour after birth, which is vital to stabilise babies' blood sugars and temperature.
- Breastfeeding initiation rates were consistently low and rarely met the national average of 82%.

However:

- The service had enough midwives to care for women and keep them safe. Staff had training in key skills, and understood how to protect women and babies from harm. Since our last inspection, the service had made improvements to make sure women received one-to-one care during childbirth
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Since our

Summary of findings

last inspection leaders had worked to make improvements to its maternity service. Staff understood the service's vision and values, and how to apply them in their work.

- All staff were committed to continually learning and improving services. The service had a Faculty of Multi Professional Learning, which delivered evidence based safe training for all staff. Fetal monitoring training and care had improved in line with best practice.
- Since our last inspection, the trust had developed a robust system to measure, monitor and analyse common causes of harm to women during pregnancy and childbirth.
- Leaders were working to improve facilities and services across maternity, the trust had invested in new equipment and drawn plans to transform the day care unit into a full maternity triage service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff shared key information to keep women safe when handing over their care to others.
- Since our last inspection, the trust increased its percentage of women receiving continuity of carer.
- During childbirth, staff completed risk assessments for each woman on admission and updated them when necessary using recognised tools.
- The trust created a digital pregnancy MOMA application, where women could access health promotion advice.
- Staff followed systems and processes when prescribing, administering, recording and storing medicines.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women in most areas. Maternity staff reduced the 3rd and 4th degree tear rate by 13% using best practice. The Singleton midwifery led unit provided excellent care, with a low transfer rate to the obstetric unit. The unit's neonatal death rate had been reduced and was in line with the national average.
- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. The unit's friends and family score for care overall reported that 97% of women who responded to the survey were happy with their care.
- Most staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.
- The service engaged well with staff, women and the community to monitor, plan and manage services.
- Leaders had recently improved the governance processes throughout the service with support from partner organisations. However, the new governance processes were not yet fully embedded.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with a requirement notice for breaches of regulation/s. Further details are at the end of the report.

Summary of findings

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Background to William Harvey Hospital

William Harvey Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The hospital opened in 1977 and is in Ashford, Kent. It is an acute hospital which serves the population of South-East Kent. Services include emergency and elective care; as well as maternity, trauma, orthopaedic, paediatric and a level 3 neonatal Intensive care unit. The site has been developed since 1977 to accommodate the increasing population.

The hospital is situated at the gateway to Europe. The area has high levels of migration and increased prevalence of common long term conditions. High levels of social and economic deprivation are reported in Thanet. Twenty-one percent of the population live in the bottom 10% of the most deprived nationally.

William Harvey Hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family Planning
- Management of blood supply and blood derived products
- Maternity and Midwifery services
- Surgical Procedures
- Termination of Pregnancy
- Treatment of disease and disorder
- Transport services, triage and medical advice provided remotely

Our inspection team

The team that inspected the maternity service at William Harvey Hospital comprised a CQC lead inspector, a CQC Inspection Manager, a specialist advisor with expertise in maternity and a specialist advisor with expertise in governance.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about William Harvey Hospital

William Harvey Hospital has one acute maternity unit that provides all aspects of maternity care, and midwifery care, family planning, termination of pregnancy and surgical procedures.

The location has antenatal clinics, day care, delivery suite, fetal medicine, with specialist clinics such as diabetes, as well as a women's ultrasound service. A counselling room was available within antenatal day care. The maternity unit had a consultant led delivery suite where women with medical complications or who chose epidurals were cared for during childbirth. Folkstone ward was for women with high risk pregnancies, postnatal and transitional care for women and their newborn babies. Transitional care was offered to babies who require extra care or observations after birth, but do not require admission to the special care baby unit.

The Singleton midwifery led unit offered low risk, straightforward childbirth for women who opted out of having demobilising pain relief.

The service worked with the neonatal intensive care unit (NICU) which was adjacent to maternity services. NICU is a high-level special baby care unit, that provides care for babies under 32 weeks or who weigh less than 1500 grams, as well as critically ill newborns of any gestation.

Summary of this inspection

We observed the ATAIN (avoiding term admissions in neonates) meeting on the level 3 Neonatal Intensive Care Unit.

There were six community midwifery teams across East Kent. They were based at children's centres and GP practices. We did not visit these services; however, we spoke with community midwives and the community matron by telephone. The service reported a 2.5% homebirth rate for the period from January 2019 to January 2020.

We observed practice, spoke with seven women and three relatives and we reviewed 15 patient records.

We spoke with 18 staff including doctors, midwives, health care assistants, reception staff, theatre technicians, and senior managers.

The hospital has been inspected three times. The most recent inspection was in August 2018. We rated maternity services as requires improvement.

Activity (From December 2018 to November 2019)

- 6,428 babies born cross-site
- 3,796 babies born at William Harvey Hospital
- 55.6% of babies were delivered normally
- 561 babies were born on the midwifery led unit
- 34.4% of babies were born by caesarean section
- 2.5% of babies were born at home

Track record on safety (January 2019 to January 2020)

Trust wide for maternity

- Zero never events
- Two maternal deaths
- Seven neonatal deaths within 28 days of birth
- Zero incidents of hospital acquired Methicillin-resistant staphylococcus aureus
- Zero incidents of hospital acquired Methicillin-sensitive staphylococcus aureus
- Zero incidents of hospital acquired Clostridium difficile

Services accredited by a national body:

- UNICEF baby friendly infant feeding stage one
- Clinical Negligence Scheme for Trusts

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- On day care, standard operating procedures were not embedded, risk assessing women was not robust and correct care pathways were not always identified quickly, to provide the necessary care and treatment.
- Early warning scores were not being calculated on day care to see whether care and treatment needed to be escalated.
- Only 75% had completed their safeguarding level 3 training. This was not in line with the trust's target of 85%.
- The service did not always manage infection control well, we found urine specimens unattended in antenatal clinic and day care, and cleaning checks were out-of-date on some equipment.
- We had concerns about the placement of newborn resuscitaires. The Women and Childrens care group leads added this to the internal risk register as a tolerated risk, to continue to monitor.
- Doctors and midwives used different methods of documentation in women's patient care records. Antenatal care pathways were not always clear, up-to-date, or in chronological order because 50% of records were stored digitally and 50% were hand written records.
- The service had limited out of hours on-call consultant and medical provision for maternity and gynaecology. This presented a risk to women who required emergency medical intervention. The service had recognised the risk and was taking steps to mitigate this, including the use of regular safety huddles.
- There were times when junior midwives worked alone in day care who did not have the necessary experience, knowledge and skills to escalate complex emergency situations. After our inspection, the trust told us they were reviewing rosters to ensure there was always an experienced midwife on every shift. After our inspection, managers told us they had reviewed rosters and made sure junior midwives were supervised, and that they could contact the band 7 maternity bleep holder to escalate concerns.
- Not all incident investigations were completed to national time frames.

However:

Summary of this inspection

- The service had enough midwives to care for women and keep them safe. Staff had training in key skills, and understood how to protect women from abuse.
- Over 95% of midwives had completed their mandatory training.
- The service had a Faculty of Multi Professional Learning, which delivered evidence based training for all staff.
- The trust had invested in new training equipment that simulated real life situations and staff attended annual updates.
- New remote fetal monitoring equipment was being installed during our inspection.
- During childbirth, staff assessed risks to women, and acted on them.
- Based on national recommendations and learning from serious incidents, the trust had implemented various safety measures to reduce the risk to women and babies during childbirth.
- Since our last inspection, the trust increased its percentage of women receiving continuity of carer.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good**:
Because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.
- Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Summary of this inspection

- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care and had access to good information. All women were routinely monitored antenatally as part of the 'saving lives' care bundle.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. Maternity staff reduced the 3rd and 4th degree tear rate by 13% using best practice. The Singleton midwifery led unit had good outcomes data for women having a straightforward low risk birth in line with national guidance and low transfer to the obstetric unit rate.
- Key services were available seven days a week.
- The trust employed two fetal wellbeing midwives and created a fresh ears and fresh eyes approach to interpreting cardiotachagraph readings.

However:

- The maternity statistics dashboard data confirmed the that the maternity unit's post-partum haemorrhage rate was 5% which is higher than the current national average of 2.7%.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- During childbirth women received one to one care from a midwife.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.
- Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. Women could access obstetric care at several satellite clinics across east Kent.

Summary of this inspection

- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- People could access the service when they needed it and generally did not have to wait too long for treatment.
- Kanga wraps were provided for women who chose to breastfeed to help keep their baby close to them.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

However:

- Maternity services did not provide a specialist women-centred consultant led perinatal mental health service, to provide continuity and time for women with mental health conditions in-line with national guidelines.
- Managers did not keep accurate records of admissions or wait times for pregnant women attending clinics and day care. We highlighted this and managers implemented changes and updated staff.

Are services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- Leaders had not always identified and escalated relevant risks or identified actions to reduce their impact. Leaders used systems to manage performance, however, these were not always effective in all areas of the service.
- On maternity day care, standard operating procedures were not embedded. Risk assessing women was not robust and correct care pathways were not always identified quickly, to provide the necessary care and treatment.
- Key patient outcome targets were not showing the targeted reduction in poor outcomes.
- The trust had not achieved compliance with all 10 actions of their safety action plan during the reporting period two remained outstanding.
- Although governance processes had improved since our last inspection with support from partner organisations, the new processes were not yet fully embedded.

Summary of this inspection

- The trust failed to report 100% of serious incidents within national time frames, data confirmed reporting did not always comply with national time frames.

However:

- The trust's vision for the planning, design and safe delivery of services was founded in an inclusive multi-professional training and audit program, using the BESTT (birthing excellence: success through teamwork) framework for maternity services.
- Since our last inspection leaders had worked to make improvements to its maternity service. Staff understood the service's vision and values, and how to apply them in their work.
- Most staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.
- The service engaged well with women and the community to monitor plan and manage services.
- 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.
- Leaders had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Research and innovation were encouraged and evidence confirmed that recently adopted models of staff training were improving outcomes for women and their babies. Staff completed evidence-based fetal monitoring training. All staff were committed to the continued improvements and development of the Womens and Childrens care group.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	N/A

Requires improvement

Maternity

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are maternity services safe?

Requires improvement

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

Mandatory training

The service supplied mandatory training in key skills to all staff which kept people safe, and made sure everyone completed it.

Midwives received and kept up-to-date with their mandatory training. Data provided by the trust confirmed that 95.6% of midwives were compliant. Cross-site 85% of doctors completed all aspects of mandatory training.

The provider had maintained their multidisciplinary learning environment. Training was planned and organised by the trusts Faculty of Multi Professional Learning in Maternity. Courses covered all aspects of obstetric and midwifery skills to support safe, emergency care and treatment.

The trust employed a lead obstetric consultant and practice development midwives to create, oversee and roll-out midwifery education across both sites.

The faculty ensured that training was delivered in line with the NHS England care bundle 'Saving Babies Lives' 2019. This focused on five key indicators to reduce poor outcomes for mothers and babies. These included smoking cessation conversations in pregnancy, risk assessments and surveillance for fetal growth restriction, raising awareness on reduced fetal movements, effective fetal monitoring during childbirth and a mental health care pathway.

Staff received two full days of skills and updates in maternity. This included modules on safeguarding at level 3. Multidisciplinary non-technical skills training (SIM) included human factors updates, risk, obstetric and anaesthetic emergencies. Anaesthetists, obstetric doctors and midwives attended these sessions. Staff told us neonatal staff had not attended in the past, although they were included in next year's training schedule.

Staff completed mandatory neonatal life support training and 96% were compliant.

Adult and newborn life support were completed on a separate training day. This was arranged by the faculty and 97% or midwives and 85% of doctors completed it.

Community midwives and paramedics completed community SIM training within a community setting which focused on obstetric emergencies in a home or community environment.

The trust used lessons learnt to update their mandatory training day for fetal monitoring. Cardiotachagraph (CTG) training was based on new physiological best practice fetal monitoring during childbirth. The fetal monitoring competency assessment framework was included in the mandatory update. All staff received a full day training and this included CTG reviews. Records confirmed that a yearly competency test had been created for all staff to reinforce learning from this session and was due to be rolled out this year.

Bi-annual training was provided to staff via e-learning modules for perinatal mental health and blood transfusion.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Midwifery and support staff received safeguarding training specific for their role on how to recognise and report abuse.

Midwives were trained to level 3 safeguarding in-line with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (2019). They routinely completed face to face or online updates.

Training included, recognition and referral of female genital mutilation (FGM) and PREVENT training, which is part of the governments counter terrorism strategy. It highlights vulnerable individuals at risk of radicalisation.

The trust set a target of 85% for completion of safeguarding training. Across both sites midwives were 98.5% compliant within the reporting period. However, only 75% of doctors had completed their level 3 training during the same period.

Staff knew who the safeguarding leads were and how to contact them. They knew how to get advice and how to make a safeguarding referral. Staff showed us how they could access safeguarding referrals via their internal trust internet system.

There were 1,900 safeguarding referrals made within the Womens and Childrens care group across all maternity sites during the reporting period and these were reviewed by the trust safeguarding leads.

Midwives and doctors knew how to protect women from harassment and discrimination. This included women with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. They worked with other agencies to protect them. Midwifery staff sent a safeguarding referral to the local authority and concerns were also flagged on their electronic patient records. This meant all staff would be alerted so they could help to keep them safe.

Maternity services followed the threshold criteria set out by the Kent Safeguarding Children Board. This meant a pregnant child under the age of thirteen would automatically be referred to the local authority. This would be classed as an offence under the Sexual Offences Act 2003. Young people that were already known to the local authority were automatically referred including looked after children. Young people with concealed pregnancies or FGM were also automatically referred.

The trust did not employ a midwife lead for teenage or vulnerable women. Teenage pregnancies of 13-18 years were assessed on a case by case basis. This was dependent on age, vulnerable indicators (for example, schooling), family support, age of partner and the stage at which they accessed maternity care.

The trust provided evidence of its involvement in serious case reviews and the learning actions from these. This meant the department was engaging with external providers and using the learning from these to improve the way it protected vulnerable adults and children.

However, staff did not always have time to monitor visitor and patient activity on Folkestone ward. Visitors, mothers and babies were not always monitored when they arrived onto the ward. We witnessed a visitor tailgate a mother onto the ward. Staff were providing care and had not completed any security checks when the visitor had used the buzzer to gain access. This meant the system was not robust and not in line with the Royal College of Obstetricians and Gynaecologists 2008, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2.2.26' Security is an issue of importance for staff, mothers and babies. A robust system must be in place for auditing the protection of babies born in hospital.

The trust had a baby abduction policy. This contained clear flow charts to guide staff.

Cleanliness, infection control and hygiene

Requires improvement

Maternity

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

The service followed the trust's infection control standard operating procedure. This ensured women and babies were protected from exposure to infection most of the time. Ward areas were visibly clean and well-maintained. Standardised hand hygiene signs were displayed at the entrance of all ward areas. Hand decontamination gel was accessible at the point of entry to each ward, and each bedded bay on Folkestone ward and the delivery suite.

Staff followed infection control principles including the use of personal protective equipment when they had close contact with women and their babies. Latex free gloves and single use gowns were available in all clinical areas. Staff wore sterile gloves and used sterile equipment for intimate patient contact.

The maternity unit completed weekly hand hygiene audits in all areas. Data for the previous month confirmed that staff were 100% compliant with hand decontamination guidelines.

In most areas furnishings were suitable for the environment. Equipment had been cleaned and was mostly in good repair. However, some recliner chairs on the delivery suite were old and in need of repair as the seats were ripped, this posed an infection risk. Staff told us that the service were awaiting delivery of new recliner chairs.

The delivery suite had been supplied with nationally standardised infection reducing partition curtains in line with the rest of the trust. However, these were not fitted on the Folkestone ward or in the day care unit. Managers told us that they were awaiting replacement of the material curtains to the disposable ones in there near future.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned most of the time. Cleaning records were up-to-date in areas and proved that all areas were cleaned regularly.

We saw evidence that staff carried out daily cleaning checks of specialist equipment. For example, weighing scales used to care for newborn babies had daily checks carried out by midwives.

Delivery packs for women during childbirth were stored in a clean room, sealed, in date and were single use items. Labels displayed the creation and expiry dates of equipment, areas we checked contained in date, safely stored un-broken packages.

Clinical waste was segregated in line with best practice. Bins were colour coded and sharps bins were clearly labelled and accessible within all clinical areas. Within the sluice room on the delivery suite, staff used double bagging to dispose of placentas. Placentas were stored in a chest freezer, which was routinely emptied.

Maternity staff completed daily fridge and freezer monitoring checks, for fridges that contained medication, breast and formula milks. Sterilising equipment was available to all mothers, so they could clean and sterilise infant feeding equipment.

Mothers and babies known to be at risk of carrying infectious illnesses were admitted to side rooms. Staff used nationally recognised barrier nursing principles whilst caring for women affected by infection.

Most consumable equipment on the delivery suite was sterile and single use, for example instrumental and childbirth packs.

The theatre was deep cleaned after each use following infection control guidelines and using a theatre cleaning checklist. Theatre staff cleaned and checked all theatre equipment. Staff wore sterile gowns and covered their hair, and during surgery used face masks.

However, we found some midwives did not use the correct process for aseptic non-touch technique (ANTT) when preparing a woman for a sterile procedure in theatre. Staff we spoke with had basic knowledge of the ANTT. The National Institute of Care and Excellence: Infection: Prevention and Control of healthcare associate's infection in primary and community care (2011) part 1.4. states that ANTT must be used for device catheter site care when accessing the system. We highlighted this to staff who told us that midwives were shown this in practice during their preceptorship programme, although this was not reviewed annually.

Also, during our inspection of Folkestone ward we found a resuscitaire had not cleaned according to best practice. This was situated in the nursery area, it was dusty and the 'I am clean' sticker was five days out of date. We highlighted this to ward staff who cleaned the resuscitaire straight away.

Also in the antenatal day care unit and the antenatal clinic, there were urine specimens in the toilet that were awaiting testing. We raised this with staff, who told us that due to space issues, this was the only area women could leave specimens and usually they were actioned at once.

The trust supplied data on infection control incidents which had occurred from January 2019 to December 2019 cross-site. This data confirmed that there had been of two incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) across both sites. The two cases of MRSA were confirmed across both sites during routine readmission swab procedures. These two cases were in the early stages of investigation.

There were 56 reported incidents of Streptococcus agalactiae streptococcus (Group B strep) cross-site during the reporting period. Managers created a checking and reporting process to make sure women could access treatment to avoid adverse outcomes for mothers and babies exposed to this condition.

Environment and equipment

The design, maintenance and use of facilities, premises were tired and in need of upgrading due to the age of the building. Although available equipment kept people safe and staff were trained to use them. Staff managed clinical waste well.

The facilities were not designed to meet the needs of women or their families. The design of the building did not follow national guidelines, because the hospital was built in 1977 and some areas were no longer fit for purpose.

The trust completed annual health and safety checks of the care environment in all areas and we saw evidence of this. Maternity scored 100% for compliance to health and safety standards in a recent review.

Staff on the day care unit completed routine equipment checks at the beginning of each shift and recorded this in their cleaning log.

Midwives and health care assistants were taught to use all equipment throughout the unit, and this was checked by the unit matron's administrator.

Facilities for the twice weekly antenatal clinic were not suitable for caring for pregnant women. For example, the area was poorly signposted and lacked hand hygiene signs. Pregnant women accessed the waiting area via the main outpatients waiting area where people with long term health conditions waited for appointments. This meant that may be exposed to health conditions acquired by the non-pregnant population.

The clinical area was cramped, with limited space to assess women. Staff told us they routinely had to bring maternity observation equipment with them to outpatients. There was limited sink space to store and test urine samples.

The resuscitation trolley was in a different area of the outpatient's unit and the inspection team noted that it took four minutes to find this. The impact of this could be a delay in vital emergency resuscitation.

The maternity day care unit was small and cramped. The unit provided a main treatment area which housed two chairs and two side rooms with treatment beds. The treatment area used to assess and treat women, was not private, and conversations could be overheard. Staff told us that this area was used for women who needed cardiotachagraph (CTG) monitoring of their unborn babies, and although there was a partition curtain this was not in use during our inspection, confidential conversations could be overheard.

The lack of space on day care meant the service could not site a Resuscitaire on the day care unit. In the event of a baby being born unexpectedly, midwives had to travel across to the delivery suite to collect a neonatal resuscitaire. The walk was approximately 250 metres between two sets of doors from the day care unit to the delivery suite, which could result in delays in neonatal resuscitation if required.

The delivery suite décor was tired and in need of upgrading, women did not have access to en-suite bathrooms, bathing facilities were available across the hall from the delivery rooms. During childbirth women would have to leave their labour room to use the toilet, or bathe. Which had an impact on privacy and dignity and posed a risk of cross contamination of bodily fluids.

Main theatres were well signposted and sited around the delivery suite on the same floor. The neonatal intensive care unit was on the same level as the delivery suite and accessible via the maternity day care unit.

Birthing rooms were small and cramped on the delivery suite. Neonatal resuscitaires' could not be stored within the birth room. Four resuscitaires were available on the delivery suite, with one sited near to the induction of labour rooms, two at the top end of the delivery suite, one of which could be wheeled in one of the larger labour rooms when a planned pre-term birth was imminent.

Finally, one was sited opposite the high risk labour room in the clinical room. This room contained the controlled drugs cupboard, and obstetric emergency boxes for postpartum haemorrhage, sepsis and eclampsia. The resuscitaire was situated in one corner, there were no piped oxygen or air facilities and staff had to rely upon routine daily checks to make sure the cylinders were full and could sustain a full resuscitation. In the case of a full neonatal resuscitation staff may struggle with the limited space and difficult access to the gas cylinders.

Staff told us that medical gas cylinders were kept in a different area of the trust, when cylinders needed replacing, porters had to bring the cylinders from another part of the hospital. The impact of this may cause delays during complex resuscitation.

All staff we spoke with told us if potential risks were identified during early stages of labour the woman would either be moved to the high dependency room or screens would be placed around the open door of the room, and the resuscitaire placed behind the screens. This gave enough room for medical and midwifery teams within the room and mother could see baby at all times.

However, if the risk was immediate and concerns were not identified during early stages of labour the baby would be carried to the resuscitaire by the midwife. This meant the baby was moved away from mother without an identification tag and the mother was unable to see or be with her baby during a potential life threatening and worrying time.

Senior leaders told us they recognised not having the resuscitaires within the rooms was not good practice and there was a lack of privacy and sensitivity for mothers and families. The Women's and Childrens care group mitigated the risk by completing a full risk assessment of the site of the resuscitaire, which included real life scenarios using a video camera. The risk assessment recognised the space limitations within the delivery suite, and confirmed that the equipment was situated in the best place possible, although the matter was placed on the trust risk register as a tolerated risk, which they would continue to monitor and review.

The trust invested in a trial of alternative smaller resuscitaire units and found they were not suitable for complex resuscitation. At the time of our inspection the trust were reassessing the possibility of installing wall mounted resuscitaires and the manufacturer had been contacted to complete an on-site assessment.

Staff told us that they risk-assessed babies due to be born early; mothers would be admitted to the largest labour room, where a resuscitaire was set up, and the neonatal team alerted of the imminent birth.

Twice daily checks were carried out on emergency equipment on the delivery suite and the data stored on the main desk within the unit. After reviewing the data we noted that during January 2020, checks had been missed on five occasions. We raised this with the leadership team who investigated. The leadership response stated, "our policy is that the resuscitaires must be checked twice daily, as further assurance, this is now discussed at safety huddles".

Clinical stock was stored safely and easily accessible to staff in all areas of maternity. Staff told us that equipment was calibrated annually, and we saw evidence of this on the equipment labels.

The midwifery led unit, was well designed, had enough rooms to accommodate staff and women during childbirth. The area was clean, well signposted, and well equipped with all emergency equipment and single use medical supplies.

We did not inspect community equipment. However, community midwives told us they had access to all the portable equipment they needed to support women who chose to deliver their babies at home.

Assessing and responding to patient risk

Staff did not always complete, or update risk assessments fully for each woman, and they did not always take action to remove or minimise risks. Staff did not always identify or act quickly upon women at risk of deterioration.

During the reporting period the hospital did not have a purpose built maternity triage unit or provide 24-hour maternity triage. This was not in line with recommendations set out in The Royal College of Obstetricians and Gynaecologist (RCOG) report Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2007. This guidance recognised round the clock maternity triage can significantly reduce the burden of unnecessary admission to the delivery suites with women presenting querying imminent childbirth, or complications associated with pregnancy.

Due to a lack of space at William Harvey Hospital, it had not been possible to implement a dedicated 24-hour triage unit and antenatal day care was the model used during the reporting period. The lack of triage created gaps in risk assessments due to the absence of a clear guideline for caring for women with unplanned antenatal complications. The trust submitted a triage plan within the Clinical Negligence Scheme for Trusts action plan, approved by NHS resolution

Staff on the day care unit were not using the national safety standardised modified early obstetric warning (MEOWS) score charts when pregnant women arrived at the department with pregnancy complications or concerns. This meant that high risk women were not always prioritised for early review by doctors. However, staff on the delivery suite and midwifery led unit used the nationally recognised MEOWS to identify women at risk of deterioration and escalated them correctly.

Although, staff completed a basic risk assessment for each woman on arrival which included a full set of physical observations completed by the maternity care assistant and clinical history taken by the midwife, who also completed a situation background assessment and recommendation (SBAR) tool. Staff told us they would use their clinical judgement to risk assess and prioritise women for care. Staff on the delivery suite and midwifery-led unit also used the SBAR tool. The inspection team found that standard operating procedures were not embedded, risk assessing women was not robust and correct care pathways were not always identified quickly, to provide the necessary care and treatment. During our inspection, staff were handed a copy of the triage standard operating procedure ratified for the Queen Elizabeth the Queen Mother site. This created some confusion for staff working in day care as it was not formally implemented for the William Harvey site. Newly qualified preceptor midwives sometimes worked alone in this high risk environment; the impact of this is that they do not have the necessary experience, knowledge and skills to escalate complex emergency situations.

Women could call maternity day care unit between 8am and 8pm with any concerns regarding their pregnancy and staff would offer them an appointment usually on the same day. However, we witnessed support staff taking calls and giving women clinical advice, and not all calls were documented. So, the service did not have full insight of the impact these calls had on their clinical work.

We raised the risk issues in the day care unit with the leadership team, who provided a formal response, which stated the following:-

- Staff were now recording and auditing the time women arrive on day care/triage.
- The trust had introduced a 'red, amber green' (RAG) rating system to assess order of priority for women to be seen on attendance.
- Times of assessment and time seen by a clinician were completed on the maternity electronic information system.
- Modified early obstetric warning score (MEOWS) charts have been introduced. All women who attend maternity triage have their MEOWS calculated. This will be added to the SBAR form.
- The trust has introduced a flowchart to support midwives decision making, setting out the RAG ratings and associated risk.

Other aspects of maternity care on the unit fulfilled national guidelines. Maternity booking appointments are a nationally recognised risk assessment of women presenting for antenatal care, designed to make sure women are placed on the correct care pathway in line with the National Institute of Health and Care Excellence (NICE) Antenatal care for uncomplicated pregnancies guidelines 2019. During womens first booking

appointment staff thoroughly assessed women to identify any pregnancy risks, and referred women when required using an assessment tool which was contained within their digital patient records. Women highlighted as 'high' risk would be referred to the obstetric teams within the trust and low risk women would continue their antenatal care with community midwives. Data we reviewed confirmed that women were given appointments in line with NICE 2019 Antenatal care for uncomplicated pregnancies guidelines.

Staff arranged psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide when mental health complications were identified. Staff used the standardised Whooley 2 depression diagnostic tool to identify women at risk of depression, in line with NICE Antenatal and postnatal mental health (2016) guidelines. Women who answered yes to both questions were offered a patient health questionnaire self-reporting tool.

Women were given their handheld notes. These included a printout of the risk assessment, advise on smoking, screening, alcohol use and fetal wellbeing.

Women were offered routine ultrasound screening, at around 12 weeks, 20 weeks and 36 weeks to assess and plot fetal growth and wellbeing in line with NICE 2019 Antenatal care guidelines. Carbon monoxide monitoring was offered at booking, and throughout their pregnancy and this was documented in their maternity record.

Women identified as having diabetes, were invited to attend a consultant led diabetic antenatal clinic, where their weight and blood glucose could be closely monitored.

Women requiring extra appointments for antenatal complications were given appointments in the day care unit, where they would be assessed by a midwife and then a doctor.

Women's risk assessments were completed to support their choice of hospital, home or midwifery-led unit birth. Women who requested a homebirth were risk assessed by the community midwives. Staff followed a strict exclusion criteria, which made sure women were managed effectively. If women were identified as high risk, the risks were explained and documented. Women who chose a home birth against medical advice were referred to obstetric clinics for a review and further risk assessments. Records confirmed that women were holistically assessed and given advice in line with national guidelines. Women carrying twins had doctor-led care throughout their pregnancies.

Mothers were assessed for venous thromboembolism (VTE) several times during their pregnancy and birth. Women identified as being high risk of having a blood clot would be offered VTE prophylaxis medication in line with NICE quality statement 9: Risk assessment – high risk of venous thromboembolism .

During childbirth delivery suite staff completed risk assessments for each woman on admission. Staff we spoke with understood the signs and symptoms of sepsis and how to implement the sepsis bundle care pathway to avoid delays in treating this life threatening condition. Sepsis grab bags were available for staff on the delivery suite, although staff on day care did not have their own stock.

The trust followed national guidance to continuously monitor babies heart rates during labour, where indicated by a risk assessment. Women identified as high risk had their babies heart rate monitored using a CTG machine, this was attached to the mother's abdomen during labour. The trust had adopted and rolled out the national physiological based CTG interpretation model and improved its focus on intermittent fetal heart rate monitoring since 2019.

Based on national recommendations and learning from serious incidents, the trust had implemented various safety measures to ensure the safety of babies during labour. For example, a fresh eyes and fresh ears approach to CTG interpretation. 'Fresh eyes' CTG reviews were carried out at regular intervals and concerns during childbirth were escalated to senior midwives and doctors who would review women immediately. The CTG reviewer would sign the CTG to make clear that a review had been undertaken.

Maternity staff used a fetal wellbeing assessment tool during labour. The tool was a sticker that was attached to the CTG monitoring printout to highlight risks to all staff caring for the woman during labour.

The trust invested in a central fetal monitoring system, which provided remote access to viewing fetal monitoring during labour. During our visit, the new equipment was being installed.

Additionally, the trust had recruited two band 7 fetal wellbeing midwives. They would support midwives with CTG interpretation and audit outcomes to ensure continuous safety improvements were made based on national guidelines.

Once babies were born, staff recorded 'Apgar scores', which measured the condition of the newborn infant, in line with national guidelines. This was to highlight any risks for all staff caring for babies in the postnatal period.

Members of the multi professional team collaborated to design and implement a neonatal newborn assessment pro-forma to document observations made at birth and throughout the early postnatal period. The neonatal assessment tool was used in conjunction with a neonatal early warning score (NEWS), to provide a thorough newborn assessment.

The newborn assessment tool rated babies using a traffic light colour code system. Red was used for high risk babies, amber for moderate and green for low risk babies. Babies scoring red or amber were provided with nationally recognised colour coded hats, so all staff throughout the unit were aware of their current condition.

Staff on the delivery suite and Folkestone ward used neonatal feeding charts, and a withdrawal observation chart to observe babies exposed to anti-depression medication, or illicit substances during pregnancy. The documentation for newborn babies was designed to support health care professionals identify deteriorations or improvements in the condition of the newborn baby.

Since our last inspection, the trust revised its escalation process for caring for women with increased risk to improve the escalation of care in the event of an emergency. Maternity introduced daily safety huddles which were attended by all professionals working on the unit, including doctors, anaesthetists, paediatricians, midwives and nurses.

Huddles were performed in the morning, again at 1.30pm. Out of hours (night time) safety huddles took place between 9.30pm and 10pm. On call consultants would dial into the safety huddle and review patient care, capacity concerns and staffing on both sites.

The names of lead health care professionals including the on-call obstetric consultant registrar and neonatal on-call consultants were displayed on a white board around the reception area. These were clearly visible to all staff and women so staff knew who to escalate to if a woman or baby needed urgent medical review.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough midwifery staff of relevant grades to keep women safe. Data we reviewed demonstrated that managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with Safer Childbirth national guidance.

Information provided by the trust confirmed that the midwife to birth ratio was 1:28 this was an improvement on the last inspection which highlighted concerns because it was 1:30 in 2018. Although, staff reported an increase of caring for women with complex health and emotional needs, which at times impacted on their workload.

In view of previous recommendations monthly audits were carried out on midwifery care during labour. Data provided to us demonstrated that the trust provides over 95% of women with one to one care during labour.

There was a systematic process in place to review staffing establishment every six months. Staffing levels were based on the number of babies born at the trust per year.

The unit employed one health roster administrator who was responsible for creating duty rosters, in accordance with the requirements of the unit. Staff were given plenty of notice of their planned rosters, which meant annual leave and study days could be planned.

There was a midwifery operational leader, who carried a bleep to ensure they were accessible to all staff. They had oversight of unit during daytime hours. The trust informed us that they plan to extend the oversight to include out-of-hours cover with the recruitment of an additional band 7 midwife.

The operational lead had access to the rosters of each area, they would be able to redeploy staff to different area's when required. For example, if delivery suite was busy, or in the event of staff sickness.

Antenatal day care was a busy environment and staff worked consistently to care for women. We reviewed the day care admission diary for the week commencing 24 January 2020 and for the seven days, staff saw 256 women. This averaged at 36.5 pregnant women per shift. On one day alone two midwives reviewed 43 women. Staff told us they were often called to help on the delivery suite, which had an impact of the day care unit's own workload.

Our last inspection highlighted concerns over the midwife to women care ratio which was one midwife to 30 women in 2018. The service had worked hard to recruit more midwives and the ratio was now in line with national targets with one midwife to 28 women. The maternity dashboard confirmed that 97% of women received one-to-one care during labour.

Shift patterns on the day care unit meant that only one midwife worked on the unit until 10am and one midwife was worked after 6pm until 8pm in the evening sometimes these were junior midwives, although a maternity care assistant supported them. We highlighted this to the trust and in their response they advised us that there would be a review of rosters to ensure that there was always a band 6 or band 7 midwife working alongside preceptor band 5 midwives.

An experienced midwife acted as a Supernummary shift co-ordinator on the delivery suite and Folkestone ward in line with the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth guidance. The co-ordinator would review staffing, the acuity of pregnant women and capacity levels throughout the shift, and work with doctors and midwives to make sure they had a complete overview on the service during their shift.

One band 7 midwife led the fetal medicine and day care unit. We noted that one whole time equivalent did not always have a full oversight of both areas and reported this to the leadership team who informed us they had been authorised to recruit another band 7 for the day care unit.

Vacancy rates

The service had a low vacancy rate.

A vacancy rate is the percentage of reported full-time equivalent (FTE) staff in post against planned workforce levels.

Since our last report the trust had recruited more midwives and staff retention was positive.

From January 2019 , the trust reported an overall midwifery shortfall of 2.3%.

Bank and agency staff usage

The service used bank and agency nurses used throughout the maternity unit. Bank staff were used to cover sickness, training and annual leave.

The trust provided bank and agency staff usage data for qualified midwifery staff and unqualified midwifery staff in maternity, broken down between the two reporting units of William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital.

From June 2019 to January 2020, the trust reported that 8,571.22 of qualified midwife hours across William Harvey Hospital's maternity unit were filled by bank staff; while agency staff filled 112.2 qualified midwife hours. These figures equate to 4.4 annual full time midwifery roles.

During the reporting period January 2019 to January 2020 the service had a sickness rate of 6.4% for doctors and midwives (for the acute maternity department) and 7.7% sickness rate on the midwifery led unit.

Medical staffing

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

The Womens and Childrens care group reported consultant staff numbers at William Harvey Hospital as 12.5 whole time equivalent.

The Healthcare Safety Investigation Branch and coroners' historic reports had raised concerns about the lack of consultant out-of-hours cover. In order to mitigate the risk of lack of cover on the unit, consultants extended their

daily hours of working until 8.30pm. This change had increased resident delivery suite cover to 87.5 hours per week and conformed to safer childbirth and RCOG guidelines, which recommend 40 hours delivery suite cover for trusts who have under 6,000 births per year. In addition, a business plan had been approved to recruit three more consultants, and the advert had been published nationally.

There were 16.4 middle grade doctors working at William Harvey Hospital with a total of 33.8 across both sites. The trust reported funding and deanery issues around the recruitment of middle grade doctors, because funding and deployment of trainee doctors was based on the number of births at the unit per year.

This current on-call system had put pressure on middle grade doctors because one registrar covered maternity and gynaecology at the same time. Staff told us that they were concerned about the risk of having to attend women attending the emergency department and maternity unit emergencies at the same time. The leadership team informed us that this risk was placed on the trust risk register as a managed risk, because the team were in the process of recruiting more doctors.

The trust had a planned elective caesarean section daily theatre list which was organised in advance. Staff told us that there was always a main theatres duty anaesthetist available on site who was available to cover emergency work.

Junior doctors told us that they felt supported and that their seniors were very supportive at all times. Consultants were approachable and made it clear to staff that they could be contacted for advice at any time during their working day.

The trust had reviewed its escalation process and implemented processes to make sure patient safety was at the centre of women's care. Consultants created a draft standard operating procedure of obstetric standards of care for the delivery suite (due to be approved during the inspection period), which would reinforce the escalation process. Staff told us they were always able to escalate their concerns. Safety huddles, on-call medics, and the planned centralised fetal monitoring system would ensure that escalation processes were strengthened.

Vacancy rates

From January 2019 to January 2020, the trust reported a consultant vacancy rate of -0.1% and a medical doctor vacancy rate of 2.1% for maternity.

Bank and locum staff usage

The service had reduced rates of bank and locum staff used on the wards.

The trust provided the total number of hours worked by all medical staff in maternity at the trust for the last six months of the reporting period. Therefore, it was not possible to calculate the percentages of medical staff hours worked by bank and locum medical staff. Instead only the raw numbers are available.

From January 2019 to January 2020 , the trust reported locum medical staff hours used in Women's and Childrens care group at William Harvey Hospital were 554 hours filled by locum staff.

Records

Staff kept detailed records of women's care and treatment. Records were not always clear, or up-to-date, because some records were stored digitally while others were paper records. Digital records were easily available to all staff providing care.

The Womens and Childrens care group used a mixture of paper and electronic medical records across all aspects of care. Notes were not always contemporaneous, and timelines and care plans were not always easy to access or read. Women's handheld records were not used by all healthcare professionals involved in a woman's care, which meant there wasn't a cohesive, succinct and safe approach to documentation.

A recent coroner's report had highlighted that a mixture of paper and digital care records posed a risk. Our inspection noted gaps in what information was available to whom and where they would access it from. Midwives in the community setting did not always have access to the internet. Two methods of documentation posed a risk during an emergency because staff might not be able to access all the information they needed to inform clinical decision-making.

Documentation within the digital system was clear, in chronological order and available to all staff who could access a computer either within the unit or at one of the satellite clinics in the community.

Access to the digital maternity records was password protected and staff accessed information on a need to know basis. The service was able to identify which staff had accessed notes and when, which ensured procedures conformed to current general data protection regulations.

We reviewed 15 sets of paper patient antenatal care records, out of these, 10 sets of records appeared to have gaps or missing entries from doctors who had reviewed women in the antenatal period. Five patient paper records did not contain a completed birth plan risk assessment. In addition, referral documentation was not clear in five sets of records, neither were doctor reviews. Staff told us that doctors preferred to input plans directly onto the digital system. Midwives in day care also input their observations and discussions directly onto the digital patient record. Which meant that MEWS charts were not being used and plotted in line with best practice. However, all 15 women's handheld records contained clear documentation from their community midwife, which included, dates, signatures, clinical observations, blood screening results and conversations during pregnancy.

The trust informed us that they were currently redesigning women's handheld notes, and moving over to a completely new digital system that they hope to roll-out in late 2020. The introduction of this system would allow women to view their maternity care in full and will support safer record keeping in the future.

During labour women's notes were hand written, staff made brief contemporaneous entries of care at regular intervals. Maternity records contained SBAR and MEWS forms, which were clearly and regularly updated. Observations, blood results, and other important information regarding care were also entered onto the digital patient records. The digital system was robust and provided health care professionals with a better oversight of antenatal care than the handheld records.

Staff told us main hospital notes were not always available to them during a womans admission to the delivery suite. This posed a risk, as the hospital notes contained significant medical, social or psychological history that was needed to provide care. Women being cared for during pregnancy at the Dover satellite clinic would need their notes transported prior to childbirth and there were times when this did not happen.

Women and newborn babies were given a discharge summary of their care during their stay before they left the unit. GPs and health visitors would be sent the information separately, so they could make any follow up appointments with women.

Records in all areas were stored securely. Paper records were kept in designated slots within the departmental office areas.

Medicines

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

Medication was stored in a safe environment in all areas. Medicines cupboards for controlled drugs were kept locked and the key was kept by the shift co-ordinator. Staff followed trust operating procedures for the prescribing and administration of medication within the unit.

All new midwives completed a medicines management competency prior to their employment with the trust. However, staff were not expected to complete a yearly medicines management competency to reduce the risk of medication errors.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs were stored separately to other medication and staff access was by a key-coded lock and a key. Controlled drug logs were kept nearby, and contained patient information and stock levels in line with regulations. Documentation we reviewed confirmed records were accurate and up to date.

Two staff members were required to dispense, check and administer controlled drugs throughout the maternity unit in line with national legislation.

Medication was prescribed manually; the trust had not yet adopted an electronic prescribing system. Charts clearly displayed patient information, including allergy information.

On the ward we observed staff reviewing women's medicines regularly and providing specific advice to women about their medicines.

Staff followed current national practice to check women had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents so women received their medicines safely. The online digital incident reporting system was used to record these incidents, which were audited by the risk midwife.

Decision-making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Doctors made regular reviews of womens medication.

Incidents

The service managed safety incidents well most of the time. Most staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, the service did not always investigate incidents in a timely way. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Learning from incidents was a high priority for the maternity unit. Consultants and senior midwives performed root cause analysis and deep dives into patient records. The trust had a cross-site investigation process in place for fresh eyes and questions from the family were included in the process.

A lead midwife was appointed to oversee the reporting and investigation of all risks cross-site. They were responsible for auditing data, reviewing policies, meeting key performance targets, allocating investigations and feeding back concerns to the leadership team.

Maternity services discharged their regulatory duty of candour. Families were now given the contact details of a member of staff who they can communicate with as required. The family also had involvement in the sign-off of the investigation reports, to make sure that the family's voice was represented and that any questions heard, and responded to within the investigation report.

Serious incident deep dive reviews were completed to identify trends and learning. Reviews included the topics of stillbirths, babies who had oxygen restrictions during childbirth and were sent for a treatment called cooling and neonatal deaths.

Most staff knew what incidents to report and how to report them. Incidents were reported through the trust's incident reporting digital software. However, some staff told us that they did not report all incidents in day care. We were told of two women who gave birth alone within the bereavement suite which had not been reported on the trust's digital incident reporting system. We raised this with the leadership team who took immediate action to update staff at daily safety huddles and team meetings.

Staff told us they were not always aware of outcomes of incidents or current audit data. Although, the trust had created strategies to make sure staff received regular updates and important news regarding updates and outcomes. These strategies included, message of the week, circulated to all staff and discussed at handover. Weekly delivery suite risk meetings were held, and all staff were invited. This meeting was rotated between each site. Meetings included presentations and discussions of recent reported incidents. Senior midwives produced a 'risky business' newsletter, which was periodically circulated to all staff and contained themes and learning points from serious incidents. Perinatal meetings were held monthly cross-site and staff were invited to attend these.

The service did not always investigate incidents in a timely way in line with national standards. Evidence provided by the trust showed there were 141 maternity incidents of which 96 low to moderate harm incidents were under review for more than 60 days at the time of our inspection. The NHS Serious Incident framework published in 2015 requires trusts to investigate and report on moderate harm incidents within 45 days. For serious incidents, a period of 60 days was recommended.

Never Events

The service had no never events on the maternity unit during the reporting period.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national

guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January 2019 to December 2019.

All serious incidents were reported to STEIS within 14 days of occurrence.

The trust reported 1,687 incidents, the vast majority were no to low harm, which is indicative of a healthy reporting culture.

Maternity services reported

- 2 maternal deaths
- 7 neonatal deaths within 28 days of birth

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service continually monitored safety performance by using a maternity dashboard. The data collected included, the amount of normal births, stillbirths, caesarean section rate and many other important aspects of care. Staff used the maternity dashboard to monitor and improve performance.

Are maternity services effective?

Good

Our rating of effective stayed the same. We rated it as **Good.**

Evidence-based care and treatment

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

Staff caring for pregnant women followed standard operating procedures which were aligned to national guidance. This included Royal College of Obstetricians and Gynaecologist (RCOG) and The National Institute of Health and Care Excellence (NICE) 2008 & 2019 Antenatal care for uncomplicated pregnancies, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2007, and the Department of Health Safer Maternity Care: National Maternity Safety Strategy – Progress and Next Steps 2017.

Policies were available on the trust internal website. File pathways were clear and easy to read. The policies we inspected were evidence based and had been reviewed within three years. Staff throughout maternity told us how they could access policies cross-site and within the community setting.

All women were treated equally, in line with the protected characteristics under the Equality Act 2010. Womens needs were thoroughly assessed. Pregnant women were given advice on maternity leave and benefits and midwives signed their maternity certificate after the 20th week of pregnancy in line with government guidelines.

Staff protected the rights of women subject to the Mental Health Act 1983 and followed the code of practice. The trust had a clear referral pathway for women experiencing moderate to severe mental health conditions. Women who needed further interventions were assessed at multidisciplinary meetings, that included doctors, midwives and mental health care professionals.

GROW charts were used to plot fetal growth in line with the Safer Childbirth minimum standards. Staff completed abdominal examinations at antenatal appointments and records confirmed this. All women were offered a universal 36 week growth scan, which checked the health of the placenta and the baby's growth. Additionally women were given information on the importance of fetal movements and the maternity notes contained information called 'count the kicks' to inform women on normal fetal movements.

The trust provided comprehensive guidelines for caring for women during labour, which were in line with best practice. Mother and baby observation charts were based on current national guidelines.

Women who required a caesarean section were cared for in the main hospital theatres. The inspection team noted that staff did not offer enhanced recovery for women who had just had their baby by caesarean, not all staff followed the correct process for aseptic non-touch technique. Midwives were task-focused and did not have time to offer advice and support for the family as they had to complete paperwork, assess the baby and prepare to accept the next patient. The impact of this was that midwives did not have sufficient time to offer mothers support with offering skin to skin contact at birth after a caesarean or breastfeeding support, which was reflected in the units breastfeeding initiation rates. Both strategies improve adaptation to life outside the womb, stabilising neonatal temperature and blood sugars.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Staff handovers included the full unit huddle, and handover to individual midwives. At each point of care midwives would make sure they handed over all details of the woman's history using the SBAR (situation background assessment and recommendation) tool which included information on their emotional needs.

Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Housekeepers would issue women on the ward menus at the start of the day, which included a variety of foods including a vegetarian option. At meal times housekeeping staff would take meals to the women's bedside.

During childbirth, and after a caesarean operation, staff fully and accurately completed women's fluid and nutrition charts, when required, using a standardised fluid balance chart.

Specialist support from staff such as dieticians and speech and language therapists was available for women who needed it. During the antenatal period, women with a body mass index greater than 35 were offered a referral to a dietician.

The ATAIN (avoiding term admissions into neonatal units) care bundle includes standard procedures to avoid new born babies developing low blood sugars (hypoglycaemia). The trust had developed an infant feeding policy, a neonatal guideline on glucose screening and a hypoglycaemia policy. Policies were updated in the last year and followed national guidelines.

Maternity services had been awarded stage one of the United Nations International Children's Emergency Fund (UNICEF) baby friendly initiative. The trust employed an infant feeding co-ordinator who was responsible for implementing all three stages of the baby friendly initiative. Their role included the promotion of breastfeeding, safe bottle feeding and training staff to teach and support new mothers with feeding. Babies were risk assessed at birth, which meant some babies needed to have their feeding reviewed three hourly. Staff used an infant feeding chart to make sure new mothers knew when to feed their babies. Additionally babies were weighed at birth, and day five, with babies weighing under 2.5 kilograms weighed on day three.

Women choosing to breastfeed and who opted for skin to skin at birth had access to 'kanga' wraps, which were wrapped around mother and baby to help with newborn temperature control, bonding and lactation. The service made these available for women to buy, and the money was reinvested into the service.

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women's Modified Early Obstetric Warning Score (MEOWS) charts contained a pain assessment scoring tool, which was completed as part of the full MEOWS assessment.

During childbirth, women requesting epidural pain relief and would be assessed by an anaesthetist who would gain consent for the administration of the procedure and explain the risks and benefits.

Staff prescribed, administered and recorded pain relief accurately. Staff completed ward rounds on the delivery suite and Folkestone ward. Midwives prescribed mild pain relief medication under the standing order prescribing procedure.

Women received pain relief soon after requesting it. Each area had its own medication storage area. Throughout the ward and day care, midwives had access to a medication trolley which meant women had access to pain relief when they needed it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

Managers collected information about the outcomes of peoples care and treatments, this was routinely monitored, and the findings were accessible to staff. Managers used information from the audits to improve care and treatment most of the time.

The service participated in all relevant national clinical audits, which included MBRACE-UK (Mother and Babies: Reducing Risk through Audits and Confidential Enquiries). ATAIN and BESTT. Additionally, the unit submitted regular data to Public Health England's national antenatal and newborn screening programs.

The NHS national screening program for pregnancy is designed to improve health outcomes for women and their babies. Maternity units are expected to comply with key performance indicators (KPI) for several aspects of care; these include, blood testing, ultrasound investigations and newborn bloodspot and infant physical examinations. In line with national guidelines the trust gathered data on all the current screening KPI's.

Ninety five percent of women attended their first dating ultrasound scan by 13 weeks and 5 days, which was in line with National Institute for Health and Care and Excellence (NICE) Antenatal Care for Uncomplicated Pregnancies clinical guidance 2019.

Women who were referred for follow up invasive screening interventions was within the national guidelines at 89.5%. The data we reviewed confirmed that reasonable efforts were made to contact all women in the correct timeframe.

Routine scans identified 66 babies with developmental abnormalities and women were offered counselling and advice on decisions regarding the continuation of their pregnancies.

Antenatal blood screening tests were offered to all women during their booking appointment. Data confirmed that just over 99.5% of all women were tested for HIV, Hepatitis B, Syphilis, Sickle Cell and Thalassaemia.

In accordance with the saving babies lives care bundle, the trust offered all women carbon monoxide screening during the antenatal period and just before they were discharged from hospital after giving birth to their babies.

During their booking appointment, 93.7% of women had their carbon monoxide levels checked, which was slightly worse than the national target of 95%. Women who smoked were offered a referral to a smoking cessation clinic. During the reporting period an average of 80% of women were referred. However, only 10% of smokers chose to stop smoking during pregnancy.

The last National Maternity and Perinatal Audit Clinical Report 2017 confirmed the national post-partum haemorrhage (PPH) rate for a blood loss of over 1.5 litres to be 2.7%. The trust provided the units maternity statistics dashboard report after the inspection, which confirmed that the trusts annual PPH rate for delivery suite was 3.4% and for the midwifery led unit 1.6% which equals a total of 5% during the reporting period which is higher than the current national average. The unit's dashboard reports post-partum haemorrhage of over 2500 millilitres with a 0.6% annual rate.

The trust reviewed the incidence of obstetric anal sphincter trauma and based on the findings had introduced training and new episcissors into practice to

reduce the incidents of 3rd and 4th degree perineal tears. Since the introduction, there had been an annual reduction of 13%. Yearly statistics confirmed that the trust met national yearly targets with an annual percentage of 2.6%.

The units CTG assessments audits confirmed that 95% of CTG assessments had a fresh eyes assessment. Out of these 87% were completed accurately.

Records confirmed that only 30% of women had an admission CTG assessment this data identified a gap in learning. Out of these 92% were completed accurately.

Initial assessments in labour to exclude chronic hypoxia (oxygen deprivation) were carried out on 100% of women and 100% were completed accurately. The audit was accompanied by an action plan with recommendations. The action plan included the introduction of attaching an admission assessment to the SBAR tool to make sure all staff completed it, in line with the recommendations of the Saving Babies Lives report of 2016.

The MBRRACE UK: Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries Across the UK 2019 report confirmed the current national average of maternal deaths is one in 10,000. During the reporting period the unit reported two maternal deaths which was two out of 6,428.

During 2019 cross site, there were 24 babies born unexpectedly outside of hospital grounds which was 1 to every 2,000 births. This was better than the national average of four in every 1,000 births.

Women who chose to give birth on the midwifery led unit (MLU), were admitted using a strict admission criteria, which established a 'low risk' status for childbirth. There were 561 babies born on the unit during the reporting period. Records confirmed that the exclusion criteria was effective as only 25 women moved from the MLU during labour. This equates to 4.6% of women who chose to use the MLU.

The service was accredited by several schemes these included the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme at level 2, ATAIN (Avoiding Term Admissions into Neonatal Units) and UNICEF (United Nations International Childrens Emergency Fund) baby friendly initiative 'baby friendly' stage 1 accreditation in 2019.

However, maternity performance was not always in line with national clinical targets. Maternity dashboard figures confirmed that the trust was not meeting the national target of booking 90% of women before their first scan at 12 weeks and 5 days. The trusts performance averaged 85% for most of the year.

The unit's emergency caesarean section rates ranged between 19% and 22% during the reporting period. This was higher than the national average of 16%. The service offered second time mothers a VBAC (Vaginal Birth after Caesarean) antenatal appointment to inform women's choices for delivery of their second baby.

The care group did not meet national targets for referring women with a high body mass index of over 35 to an obstetric consultant clinic at booking. Data confirmed that only 75% of women were referred within four weeks of their initial booking assessment.

The maternity dashboard confirmed that venous thromboembolism (VTE), assessments were completed for 92.1% of women for the whole year which was slightly worse than the 95% national target. The impact of this meant some high risk women could miss time frames for being prescribed blood thinning medication.

Neonatal Outcomes and National Neonatal Audit Program

The trusts neonatal audits were in-line with national standards and data was collected and reviewed and accessible to all staff.

In the 2019 national neonatal audit the trust's performance in the two measures relevant to maternity services was as follows:

All mothers who delivered babies from 24 to 34 weeks gestation inclusive were offered a dose of antenatal steroids. There were 185 eligible cases identified for inclusion. Of these, 85.1% of mothers were given a complete or incomplete course of antenatal steroids. This was within the expected range when compared to the national aggregate, where 86.1% of mothers were given at least one dose of antenatal steroids.

Mothers who delivered babies below 30 weeks gestation were given magnesium sulphate in the 24 hours prior to delivery. The Prevention of Cerebral Palsy in Preterm Labour (PReCePT) program is reducing the incidence of cerebral palsy by offering magnesium sulphate to all

eligible women in England during preterm labour (less than 30 weeks). The trust had created PReCePT leads who made sure that women at risk of pre-term birth were offered magnesium sulphate. The hospital met the audit's recommended standard of 85% for this measure.

Neonatal admissions were reviewed at a weekly multidisciplinary meeting, attended by the neonatal doctors and midwives. During the reporting period the percentage of term babies admitted to the NICU unit was 2.9%, which is better than the national average of 3.6%.

The government's national term stillbirth rate target for 2020 is set at 2.6%. The MBRRACE UK: Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries Across the UK 2019 report confirmed a national average of 2.8 babies per 1,000 births during its last two-year reporting period. The William Harvey Unit was meeting this target with figures for the reporting period of 1.9%. The unit reported two neonatal deaths of babies within 28 days of birth.

Trust data for babies having skin to skin contact with their mothers at birth was 72% across both sites. This did not meet the current national average captured through NHS Maternity Statistics, England 2018-2019 which was 82% for the period. UNICEF baby friendly standard states: Support all mothers and babies to initiate a close relationship and feeding soon after birth. This figure may reflect the rate of women having caesarean section although staff told us that women were offered skin to skin in theatre.

There are various reasons for low breastfeeding initiation rates, which include, lack of conversations during pregnancy, lack of antenatal breastfeeding education and women's attitudes towards breastfeeding. Staff told us that breastfeeding classes in the community were limited.

During the reporting period 344 babies were re-admitted to the hospital within 28 days of birth. However, babies admitted under 10 days were admitted to the children's ward and not the postnatal ward. This meant the infant feeding co-ordinator did not have an oversight of readmissions for weight loss and feeding complications in line with the UNICEF baby friendly guidance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff records confirmed that all newly qualified midwives, completed a full induction, and a year as a preceptor. New staff attended the administration of medicine course on starting at the trust and had to complete the competencies during their preceptorship. In the last year, all band 5 midwives had completed this competency.

The women's care group provided a full induction for locums and records confirmed this. Locum doctors completed a competency document prior to working on call out-of-hours. The document included bleep holder details for all medical staff; details of shift handover times, emergency call numbers, access to guidelines and policies and information on the required mandatory training. Moreover, the document gave an overview of important information. For example, the process for accessing CTGs for women on oxytocic medication that helps induce labour, the use of episcissors for childbirth and swab count procedures. Once the orientation was completed, the document was signed off by a consultant or senior registrar.

Further training was offered to staff on a once only basis, for example the UNICEF baby friendly initiative infant feeding training was a full one off day, with a three yearly update to be completed online. Staff also undertook one off e-learning for Venus Thromboembolism prevention in practice and ATAIN e-learning modules.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. The trust introduced TRiM (Trauma Risk Management) in 2019. Some staff are TRiM practitioners and TRiM managers.

Managers made sure staff received any specialist training for their role. Specialist midwife roles were created for various clinical conditions, these included, diabetes, fetal wellbeing, perinatal mental health and bereavement midwives.

Managers identified staff training needs during appraisals and mandatory training, and gave them the time and opportunity to develop their skills and knowledge. A birthing excellence: success through teamwork (BESTT) steering group was responsible for overseeing and progressing the actions required for the achievement of deliverable teaching sessions that were aligned to the action plan.

There were enough clinical educators to support staff learning and development. The trust employed practice development midwives and a lead consultant for education, who were responsible for overseeing the education workstream aspect of the BESTT program.

Some midwives felt that they encountered barriers to completing mandatory practice assessor or newborn and infant examination assessment training. Both skills are vital for career development and allow practice assessor midwives to support assessments of student and the latter to support paediatric doctors with newborn examinations.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Additionally, the trust promoted a national leadership programs for obstetric and midwifery staff.

Senior staff attended team meetings. Midwives and doctors involved in cases were invited or had access to full notes when they could not attend.

Managers identified poor staff performance via monitoring, incident reporting and feedback. Any staff who underperformed were promptly reviewed and managers supported staff to improve.

Appraisal rates

Maternity managers supported staff to develop through yearly, constructive appraisals of their work.

Data provided by the trust confirmed that from January 2019 to Jan 2020, 85% of all staff in maternity at the trust received an appraisal which met the trusts target.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. Ward rounds were attended by doctors, midwives and, where applicable, any specialists involved in care.

Staff worked across health care disciplines and with other agencies, when required, to care for women. Doctors and midwives worked with specialists across the hospital trust. These included physiotherapists, speech and language therapists, neonatologists, paediatric nurses, safeguarding leads, and when necessary social services. Staff caring for women who were subject to care orders would liaise with social care, mental health services and where applicable substance misuse leads. Staff involved in complex cases would attend case conferences as part of the multidisciplinary process.

Staff referred women for mental health assessments when they showed signs of mental ill health and depression. Staff used a standardised assessment tool and there was a specialist perinatal mental health midwife who supported doctors and midwives caring for women with mental illness.

Seven-day services

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

Midwifes, consultants and anaesthetists were available on site. Consultants were available on site from 8am to 8.30pm Monday to Sunday. Out of hours consultants were on call from home and would attend the unit when required. Obstetric doctors, midwives and anaesthetists provided 24 hours seven day a week cover for the delivery suite, Singleton unit and the Folkestone ward.

Consultants led daily ward rounds on all wards, including weekends. High risk women were reviewed by consultants throughout the maternity unit. The unit did not receive funding for 24 hour on-site consultant cover. To mitigate this risk, on call consultants dialled into a 10pm huddle, with some consultants opting to sleep in the staff accommodation if they felt the unit was under pressure, or there was a complex woman in labour on the unit.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There were on-site pharmacy and pathology services that were available at all times of day and night. Maternity services offered a 24-hour triage service. This service could be accessed at any stage of pregnancy.

Fetal anomaly screening was available Monday to Friday from 8am to 8pm. Urgent ultrasounds examinations were available on the day assessment units during these times.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on every ward/unit. The trust had devised a digital application for health promotion, that women could download on to their smart phones. Information contained in the app related to common pregnancy conditions, advice, support for smokers and information on fetal wellbeing.

Throughout maternity services, women could access patient information leaflets on various health conditions. Women who were diagnosed with conditions which included, diabetes, group B Streptococcus, obstetric cholestasis and other pregnancy related conditions were given written information at their appointments.

Screening booklets were sent to women when they booked for their antenatal care. The NHS screening leaflet contained information on screening pathology tests, ultrasound test and newborn screening for babies after birth.

Staff assessed women's health when admitted and provided support for any individual needs to live a healthier lifestyle. During women's stay on the ward, staff offered carbon monoxide testing, infant feeding support and advice on caring for their baby.

Additionally women had access to a digital pregnancy application created by the trust known as the MOMA app where they could access pregnancy health advice in-line with national guidelines.

All aspects of maternity services were represented in the governance review meetings. Matrons and band 7 midwives are invited to meetings and involved in decisions regarding the delivery of services.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures to limit women's liberty in the event of chronic mental illness.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. If midwives were unsure of a womans capacity to make an informed decision, then they would liaise with the doctors.

During our inspection, we witnessed staff gain consent from women for their care and treatment in line with legislation and guidance.

When women could not give consent, medical staff made decisions in their best interest, taking into account the health needs of the mother and baby, the impact on the wider family and their cultural beliefs and traditions.

Staff told us that women with learning difficulties would be picked-up in community and a care package would be organised by the community multidisciplinary team. Some midwives we spoke with appeared unsure of the process for gaining consent for invasive procedures such as vaginal examinations, neither did they know where to find the consent forms. Although staff did state they would make sure a doctor was asked to review these mothers.

Staff made sure women consented to treatment based on all the information available. For example, women who declined blood test screening were offered follow up appointments, further information and a doctor's referral. Staff clearly recorded consent in the woman's records.

The trust dealt with mothers as young as 13. Staff made adjustments to care and made sure extra support was provided. Staff used the Gillick Competence and Fraser Guidelines to assess young women and make informed decisions regarding their care.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

Midwifery staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental Capacity Act and Deprivation of Liberty Safeguard training is included in trust induction. From January 2020, midwives' perinatal mental health awareness training was included in the mandatory maternity update day.

Doctors completed dementia awareness training, which covered gaining consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Midwives were responsible for highlighting women with mental health concerns, during the booking risk assessment and throughout the antenatal and postnatal period. Midwives would refer women experiencing mental ill health to the obstetric team or the duty psychiatrist for further care and treatment.

Women who had delivered their babies, but were subject to the detention under the Mental Health Act 2005 were isolated to side rooms, while undergoing case reviews. Once decisions were made regarding their care, staff would find them a placement on a mother and baby unit, within the South East of England. Although, staff told us that due to lack of facilities locally, there were times when very unwell mothers were sent to other parts of the country.

Are maternity services caring?

Good

Our rating of caring stayed the same. We rated it as **Good**.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Staff followed procedures to keep women's care and treatment confidential when possible. Women across the service had risk assessments completed in private, except in the day care unit where space limitations meant some women may need to share a room with others. However, staff made sure that confidential information was discussed in a private area.

The design of the bedded bays on Folkestone ward meant that only partition curtains separated pregnant women and new mothers. Staff would discuss normal patient care with women at the bedside, if mothers wanted to speak in confidence, staff would take them to a private area.

Midwives and support workers we spoke with, were advocates for women. Staff had non-judgemental attitudes towards women and displayed understanding when talking about women with mental health concerns, substance misuse issues and learning disabilities.

During pregnancy women were allocated a community midwife who would provide continuity throughout the pregnancy for most of the time. During childbirth, women received one-to-one care most of the time in line with national guidelines. Women built trust with their midwives, which was vital for making informed decisions regarding their care and treatment.

Women told us that staff treated them well and with kindness. Woman told us they were happy with their care and one woman we spoke with told us support staff had spent a long time helping her to care for her baby after a caesarean section, despite the ward being busy.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Midwives and doctors understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs, and 96% of midwives had completed diversity training. Women could request a female doctor for intimate procedures. Additionally, the trust provided a multi-faith chapel. Vulnerable women were referred to third party services.

We saw an example of a woman who had previously experienced the loss of her baby during pregnancy being given extra antenatal appointments to reassure her throughout her pregnancy.

Emotional support

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

Requires improvement

Maternity

Staff gave women and those close to them help, emotional support and advice when they needed it. Midwives and support workers understood the impact for women who had difficult pregnancies and childbirth, and wellbeing was assessed throughout their care.

Since our last inspection, the trust increased its percentage of women receiving continuity of carer. Women told us they saw the same midwife throughout the antenatal period within community clinics.

Midwives and support workers supported women who became distressed in an open environment, and helped them maintain their privacy and dignity in difficult circumstances. Women who had been given bad news regarding their babies' wellbeing during an ultrasound scan, were taken to a quiet area and comforted and given time to accept distressing news. Staff supported women to make advanced and difficult decisions about their care, and women and their families were given time to absorb and assimilate bad news.

Women and families who lost their babies had time with their babies, because the trust had invested in cooled cots, and there were clear procedures to allow parents to take their babies home to grieve in private.

The trust employed two bereavement midwives who helped parents with their loss and the funeral arrangements. Staff on the unit told us they completed an e-learning training module to help them deliver the best care for families who had experienced the loss of their baby.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service had a postnatal listening clinic for women who were affected by a traumatic birth.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Throughout the maternity unit, we observed staff holistically assess women's needs and preferences. Midwives and doctors shared evidence based advice, and women were true partners in their care.

Staff made sure women and those close to them understood their care and treatment.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback forms were available in all areas and when women were discharged they were given a form.

Staff supported women to make informed decisions about their care, during risk assessments, during childbirth and prior to discharge.

The feedback from the Friends and Family Test was positive for all areas. Friends and Family test performance data provided by the trust confirmed that 97% of women who responded to the test would recommend maternity services to other pregnant women.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey of January 2020. During the summer of 2019, a questionnaire was sent to all women who gave birth in January and February 2019 at smaller maternity units. The CQC received responses from 160 patients at East Kent Hospitals University NHS Foundation Trust. We asked people to answer questions about different aspects of their care and treatment. Based on their responses, we gave each NHS trust a score out of 10 for each question (the higher the score the better). The trust scored 9 out of 10 for care during labour. However, women scored the service 6.2 out of 10 for having the opportunity to ask questions about their care during labour. It is important to note these scores reflect care across both sites and were similar to other trusts providing maternity services.

Are maternity services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good**.

Service delivery to meet the needs of local people

Requires improvement

Maternity

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

Managers planned and organised services, so they met the needs of the local population most of the time. Space limitations due to the design of the building had acted as a barrier to further changes, although plans had been made to improve access and service delivery in the near future.

The maternity unit had implemented several workstreams to make sure that women across the trust could access care when they needed it. Consultants identified three themes for providing the best care, reduced variations in care, consistent language and formal leadership. This work contributed to the revision of maternity care within East Kent Hospitals University Foundation Trust.

Women had easy access to antenatal care, all women could self-refer through an online webform on the trust's website. A central booking office processed online referrals and sent them to the appropriate midwifery team to arrange the booking. Women with complex health needs were booked early and referred for consultant care at the relevant unit.

Delivery of antenatal care was in line with National Institute of Health and Care Excellence (NICE) Antenatal Care: quality statement 2: continuity of care. This states, "pregnant women are cared for by a named midwife throughout their pregnancy". Women were booked in the community by one of seven midwifery teams and remained with the same midwife, and a buddy midwife throughout their care, unless their care plans changed.

Mothers were offered maternity care at children's centres and doctors' surgeries throughout East Kent. Women living outside the area could choose to book with the service. Although, midwives completed their bookings at the hospital these women did not receive the same antenatal continuity of having the same midwife at each appointment, as they attended the hospital for their appointments.

Administrative staff monitored missed antenatal appointments and took action to minimise risk. Staff contacted women who did not attend. If they did not respond or failed to attend a follow-up appointment, staff liaised with the woman's GP.

Maternity service managers employed specialist midwives for perinatal mental health, diabetes, and bereavement. However, they did not provide a specialist service for teenagers or vulnerable women.

The care group employed two perinatal mental health specialist midwives. However, at the time of our inspection the maternity unit did not provide a dedicated consultant led perinatal mental health service for women in need of additional mental health support, or specialist intervention. Staff told us this was not in-line with NHS England's Perinatal Mental Health Care Pathways 2018 recommendations. NICE Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (2020). This states, "there should be a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams". The trust advised that there were plans to recruit a consultant with a special interest in perinatal mental health. Records confirmed that 66 women were identified as having serious mental health problems at booking during the reporting period. The impact of this was that women were referred to their GP for further assessment, or signposted to local community services, putting the onus on vulnerable women to manage their own mental health needs whilst waiting for an appointment.

The delivery of peri-natal mental health services across the trust meant women sometimes had insufficient time dedicated to meeting their mental health needs at each maternity appointment. The perinatal mental health midwife did not have a caseload of women. Instead they were there to offer to support and deliver teaching sessions to their midwifery colleagues. The impact of this was that community clinic midwives, would have to provide care for all women for 20 minute appointments, which is limited time in which to discuss emotional care with vulnerable women.

Staff could access emergency mental health support 24-hours a day, seven days a week for women through

the trust switchboard, who would contact the on-call psychiatric team. However, staff told us that there were times when women had to wait for long periods before a member of the mental health team could review them. Also waiting times for attendance were not monitored, .

Community midwives followed-up women who had severe depression within the community setting with selective visits, and joint visits with mental health professionals were encouraged.

The service worked closely with the local stakeholders such as the Maternity Voices group to improve care, so that it would meet the needs of the local population. Maternity services looked at different ways of supporting parents. This included the introduction of longer clinic times to make sure that women had time to talk about any their pregnancy concerns or discuss their birth plan. It also provided an opportunity for mothers and their partners to be signposted to therapeutic services like hypnotherapy for childbirth – a natural birthing process which helped women cope during childbirth had been piloted at the Queen Elizabeth The Queen Mother Hospital. Once evaluated, there was a plan to provide this service at William Harvey Hospital.

Maternity services had worked in partnership with the local clinical commissioning group to create a frenulotomy clinic for newborn babies born with tongue tie, who were struggling to feed. This meant that women did not have to travel to London as they had in the past. Mothers and babies were now referred, seen and treated quickly to improve their ability to breastfeed.

The service had worked in partnership with external services to create antenatal education videos, which women accessed via the trust's maternity website. These included, during your pregnancy, your delivery, after the birth and feeding your baby.

The delivery suite had recliner chairs so that partners could stay during childbirth. Partners were permitted to stay on the postnatal ward.

Meeting people's individual needs

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

The service delivered care in line with NICE clinical guideline 10 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. The guidance makes the following recommendation "Service commissioners should make sure that trusts record the number of women presenting for antenatal care with complex social factors". Records confirmed that the trust kept data for women presenting for care with raised BMI, diabetes, complex mental health issues, non-English speaking, substance misuse and young parents.

The trusts self-referral form for women asks questions relating to women's ethnicity, first language, previous medical and obstetric history.

Staff made sure women living with mental health problems, learning disabilities and dementia received the necessary care to meet all of their needs. Women with complex needs had up to date care plans. Staff discussed care choices with women and their families and completed regular reviews. Community midwives would complete maternity concerns forms which helped flag these women for extra services. Social care referrals were made in some instances to help women in need, and midwives would liaise with childrens centres to off community support groups.

NHS Englands national maternity transformation programme's workstream 9 focuses on a range of initiatives to improve wellbeing, reduce risk and tackle inequalities from preconception to 6-8 weeks postpartum. East Kents areas of social deprivation contribute to higher instances of obesity, smoking and poor health. The trust employed a consultant midwife for public health. They did not follow women through their pregnancy and birth but focused on tackling health inequalities within the area, and overseeing national screening programs.

Women who requested a caesarean because of tocophobia (anxiety about childbirth) were referred to a doctor for review.

Community midwives ran a monthly short antenatal class. However, the trust did not provide infant feeding antenatal education within the community.

The service offered transitional care for term babies who needed to stay for observations or medication. This meant that babies with moderate medical problems

could stay with their mothers on the ward, where they could be cared for by midwives and visited by paediatric nursing staff for medication, instead of being admitted to the neonatal intensive care unit.

The service was responsive to the needs of parents following baby loss. Parents who lost their babies, were cared for on the 'twinkling stars' bereavement suite. The room was designed as a 'home from home' environment. Families could grieve in private and were given time to come to terms with their loss. One parent told us that staff had been compassionate and supportive and that they had been allowed to spend time with their baby.

The bereavement midwife would co-ordinate care for women who had lost their babies. The midwife would complete all the necessary documentation, organise time for parents to spend with their babies, liaise with colleagues and make sure that community teams received updates regarding the family's situation. Doctors debriefed parents following baby loss. Parents were given information on burials and cremation services within the community. Community midwives were notified and women who had experienced a loss could have their postnatal checks completed in the community.

NICE Antenatal and postnatal mental health: clinical management and service guidance (2020) State "health care providers should offer all women help and support if they need it", to reduce the impact of trauma on women's long term mental health. The service provided a 'birth after-thoughts' clinic for women who had experienced a traumatic birth and wanted to debrief and review their care records. A named band 7 and band 6 midwife ran these clinics. Given the national imperatives for high quality maternity care, the consultant midwife role did not follow anxious women through the care continuum to support positive outcomes following a previous trauma.

Policies were in place to support the care of women suffering from mental illness after birth. Staff liaised with mental health colleagues so that women could be reviewed in line with NICE Antenatal and postnatal mental health guidance. Women experiencing chronic mental health issues would have to wait on the ward for the trust psychiatrist to review them. The system was complex which meant that there were times when these women would have to remain on the ward for up to a week to await transfer to mother and baby units. When necessary extra carers were employed to monitor them until they could be transferred to a mother and baby unit.

The service met the communication needs of women who spoke different languages. During the reporting period, the trust cared for 235 non-English speaking women, who were offered an interpreter for their booking in appointment. During routine appointments, midwives used a telephone interpreting service to communicate with women. Staff told us that in the event of an emergency the trust used a tannoy service to call upon bi-lingual colleagues to help with interpreting. The service did not provide leaflets in other languages; however, staff knew that NHS screening leaflets were available in various languages, which they accessed online.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

During the reporting period women attended day care 3,958 times for planned appointments. Women, doctors and community midwives could refer to the service and were seen very quickly most of the time. The service received 3,687 unplanned appointments for women during the reporting period. This equates to 21 women per day who accessed day care during the reporting period. Staff told us that the impact on workload during periods of high demand was challenging because staffing rarely met the needs of the service. This happened frequently in the late afternoon and early evening.

The service provided satellite obstetric antenatal clinics across east Kent, which reduced travelling times for pregnant women. Obstetric clinics were available in Dover, and Canterbury which offered emergency scans and fetal monitoring. Women could access the clinics for planned appointments or unplanned attendances if they had developed health concerns. Records showed that 8,182 women were seen at these satellite clinics during the reporting period.

When women were discharged from the unit, they were given the contact details of the hospital and community midwifery teams in the event of complications. Maternal readmission data provided by the trust showed that 195 women were readmitted within 48-hours of childbirth, this equates to 5.1%.

Managers and staff worked to make sure that they started discharge planning as early as possible. Although parents had to wait for the neonatal doctors to complete newborn and infant physical examinations. There were several midwives on the unit trained to complete baby examinations and if the unit was very busy staff would be allocated to support the paediatric doctors and check low risk babies. On the ward, one midwife had completed their prescriber training and another was waiting for confirmation on their professional registration. This meant that midwives could prescribe medication when doctors were unavailable, and this helped to speed-up the discharge process.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Doctors and midwives would assess women for discharge home from the ward. The discharge documentation was completed by a band 3 discharge co-ordinator on the authority of the healthcare professional. Women were given a discharge notification, postnatal care leaflets and contact telephone numbers.

Concerns were flagged to the shift co-ordinator and staffing was reviewed when the unit was busy. The unit had to divert women in labour three times during the reporting period to its neighbouring site.

Staff supported women and babies when they were referred or transferred between services. Women would receive a discharge notification that listed their care and medication during their stay. Community midwifery teams would be informed of the discharge and women were visited the following day after discharge home with their baby. Notifications were sent to the GP and the health visiting teams, any baby needing a paediatric follow-up would have appointments sent to their parents.

Before our inspection, managers in day care had not monitored wait times for routine or emergency appointments. The impact of this was that women may not have received urgent treatment within agreed timeframes and national targets. When we highlighted this to managers, they implemented changes to the admission diary to reflect arrival and wait and seen times in line with national guidelines.

Although managers had not previously monitored wait times, they took steps to try to make sure that women did not stay longer than they needed to. For example, on day care, one midwife had completed their sonographer training, so that they could assist with ultrasound scans..

Inductions were planned and women were admitted to an area of the delivery suite and monitored throughout their stay.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. There was a clear process and patient information leaflets were available in all areas, with information including contact details.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes and shared the outcomes with staff via newsletters and feedback. Matrons would triage complaints and allocate them to the relevant band 7 shift lead for investigation and a response. The matron would review the response and create a written response within 28 days of receiving the complaint which was in-line with the trusts complaints guidelines.

Ward staff had listened to women's feedback about noise levels on the ward during the night. The unit had invested in earplugs for women and these were provided on request, to help women sleep.

Are maternity services well-led?

Requires improvement

Our rating of this well-led stayed the same. We rated it as **Requires improvement.**

Requires improvement

Maternity

For this core service inspection our assessment of well led is an assessment of the leadership, governance and management within the Womens and Childrens care group. However, we did interview the trust's medical director and chief nurse during this inspection."

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles. However matrons did not always have sufficient time to drive improvements due to their large portfolio of responsibilities.

The service was led by a triumvirate structure consisting of a clinical director, head of midwifery and operations director. The triumvirate engaged and communicated with staff and worked well together. A new obstetrics speciality clinical lead and new site leads at each maternity unit strengthened clinical leadership across the sites delivering services, together with a senior midwifery structure introduced by the head of midwifery after their appointment in 2018.

A senior consultant who was educated and experienced in transforming healthcare worked 50% of the time in clinical practice and 50% in a lead education role. They led on improving and supporting delivery of training as part of the trust's BESTT (birthing excellence: success through teamwork) programme. Staff across the care group spoke highly of the work they had done to improve training.

The head of midwifery was the driving force behind change. The triumvirate reported to the chief of operations. The chief nurse did not have responsibility for the delivery of the maternity transformation program. The head of midwifery was professionally accountable to the chief nurse and they had regular one to one meetings.

The chief nurse was the trust board maternity champion and had confidence in the head of midwifery and the multidisciplinary team to deliver the improvement agenda. The Womens and Childrens clinical director, and head of midwifery were local safety champions. They met bi-monthly. The chief nurse attended quarterly meetings with the Health and Safety Investigation Branch (HSIB), was responsible for final responses to complaints and every month reviewed the friends and family test.

The deputy head of midwifery was responsible for overseeing staffing, safety and effectiveness at William Harvey Hospital. The unit employed two matrons, one for the oversight of services within the unit and one for overseeing community midwifery services. Both were accountable to the leadership team for working practices within their area. Matrons were responsible for updating staff on changes to practice, compliance, incident reviews and auditing services to meet national and internal targets.

Some senior staff did not always have sufficient time or resources to drive the transformation program and other improvements. The unit matron represented numerous services from fetal medicine, day care, antenatal, intra-partum and postnatal care. Some staff raised concerns at their ability to improve clinical quality and staff experience with such a large responsibility due to concerns about women's assessments and wait times in day care. The leadership team did not have a full oversight of service provision on the maternity day care unit, and did not collect accurate date for admission and wait time data prior to our inspection. This was not in line with Safer midwifery staffing guidelines, which set out the need to monitor delays of 30 minutes or more in providing triage care, missed or delayed care throughout the unit and full clinical examinations not being carried out. All of these indicators represent potential 'red flags' for safe midwifery staffing, therefore it is important they are monitored to ensure safe staffing levels.

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.

The trust had been forced to review services amidst public concerns about safety and performance. During our inspection the trust issued a public statement which confirmed changes were ongoing stating, "We recognise,

however, that the scale of change needed in our maternity service has not taken place quickly enough and we need to fully embed further learning and changes to our culture."

The trust vision for the planning, design and safe delivery of services was founded in an inclusive multi-professional training and audit program, using the BESTT program for maternity services. The framework provided a quality improvement program in maternity services to address the lessons learned from serious incidents and key themes highlighted by HSIB and NHS Improvement. Workstreams were aligned to national guidelines, and focused on reducing the number of stillbirths, admissions to neonatal intensive care and skin tears during childbirth. The trust was entering year three of their transformation program and achieved eight out of 10 of their workstream targets. These principles were based on the Safer Childbirth 2016 report, standards for the organisation and delivery of maternity care.

A task and finish group was set up by the care group which focused on workforce and job plans as part of the maternity transformation program had been introduced to improve key areas set out within the National Maternity Review report 2016 . The purpose of this is to provide senior presence in obstetrics and paediatrics to ensure appropriate cover of women's and children's services.

The task and finish group reported to the Maternity Support Program learning and review committee, which had an externally appointed chair. The trust has been supported in creating and complying with strict governance guidelines.

Culture

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

Most staff felt the culture within the care group had improved over the last two years. Doctors and midwives felt respected, valued and involved with service improvements.

In view of historic concerns with regards to the culture within maternity services; the midwifery leaders promoted a culture of learning and continuous improvement to maximise quality and improve outcomes for women and babies. Staff were invited to attend meetings for practice updates; leaders also sent newsletters and emails of quality improvement measures. Furthermore, BESTT improvement audit data was displayed on boards throughout the unit.

During the inspection, the trust had attracted a lot of national press attention due to a coroner's review of two babies that had sadly died in the past, while under the care of the units. Midwives and support workers had been placed in the public spotlight, which some found unsettling and upsetting for the families concerned. A few staff had been personally involved with case reviews, and others had supported their colleagues through challenging times. Despite this, most staff we spoke with were reflective, showed compassion for the families and were passionate about the maternity unit and the care that was currently provided. Many spoke positively and were proud of the recent improvements that had been made.

Doctors told us they felt the culture had significantly improved over the last two years. Consultants were approachable and willing to listen to recommendations. Concerns were escalated appropriately by staff and a support network was created which encouraged effective training and development. Funding from the deanery was cited as a barrier to recruitment as this was based on the total number of births across William Harvey maternity unit. Although the deanery were proposing a change, the details were not clarified during the reporting period, and the trust was recruiting more middle grade doctor.

The majority of staff had worked for the service for many years and staff confirmed they felt they were part of a working family. Staff turnover was under 5%.

Staff were open and honest and understood the principles of duty of candour within maternity. When things went wrong, staff would escalate to their managers and doctors, and complete incident reports.

In most areas of the unit, staff felt they were able to report incidents without the fear of being liable. However, some staff in antenatal services told us they felt incident reporting for internal staffing or workload issues were not

encouraged by the management team. We raised this with managers, who spoke with staff to reassure them that reporting incidents helped inform and change practice when necessary.

Although the trust had a freedom to speak up guardian and a whistleblowing policy, some staff we spoke with were unaware of these systems which supported transparency within the workforce.

However, although most midwives acknowledged improvements in culture, several support staff at William Harvey felt that there had been a lot of focus on improving the service at Queen Elizabeth The Queen Mother Hospital and that the William Harvey Hospital improvements had been delayed because of this. Support staff told us they felt frustrated by this. Support workers we spoke with felt there was no career progression or development from band 2 to band 3 and their workload had increased. This impacted on their morale and emotional wellbeing, and they felt undervalued.

On the whole, staff were supportive and appreciative of their relationships. Teams worked collaboratively and staff spoke highly of the unit matron. Staff shared responsibilities and any conflict was resolved quickly and constructively.

The trust promoted equality and diversity throughout the organisation and beyond. Staff told us that they felt protected characteristics under the Equality Act 2010 were respected by managers and throughout the care group.

Governance

Leaders had recently improved the governance processes throughout the service with support from partner organisations. However, the new governance processes were not yet fully embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There had been improvements to multi-professional simulated training and investments had been made in new remote electronic fetal monitoring equipment. The midwifery workforce had stabilised, and new escalation procedures implemented. Out of hours safety huddles were attended by all staff and compliance to this was monitored. The trust's obstetric standard of care procedure had been drafted and was due to be published. The trust supported by a maternity transformation program had taken steps to mitigate risks to women, babies and their families.

The trust's governance and management model was supported by external third parties, which included NHS improvement and commissioners. The maternity Womens and Childrens care group had been reconfigured in 2018. They were previously included in a multi-speciality division, along with cancer, and had no voice within that division. This was the first inspection since the reconfiguration. New site leads had been appointed to ensure that governance and improvements were carried out.

The governance structure included a structure of meetings to ensure oversight, reporting and particularly clinical engagement at each site. The structure was demanding on the triumvirate because meetings limited their time to develop the strategy for the service and deliver the necessary change at pace. They made significant progress despite this challenge. However, the pace of change was an issue as some of their key patient outcome targets were not showing the targeted reduction in poor outcomes.

The trust was a member of the Clinical Negligence Scheme for Trusts (CNST) which handle clinical negligence claims against NHS providers. In August 2019 the Trust declared compliance with year two of the maternity incentive scheme, which is designed to improve quality and safety in maternity services.

However, when the submission was rechecked, the trust had failed to meet two (safety actions 5 and 8) of the ten requirements for the period between January 2019 and August 2019. The trust did not fully demonstrate an effective system of midwifery workforce planning to the required standard. Additionally, the trust were unable to evidence that at least 90% of each maternity unit staff group had attended an 'in-house' multi-professional maternity emergencies training session within the last training year. This meant the trust were not able to assure NHS Resolution that they were compliant with all ten maternity incentive scheme safety actions.

Requires improvement

Maternity

The trust was supported by the NHS Maternity Support Program , which included support from a director of midwifery from a trust rated 'Outstanding' by CQC; a consultant obstetrician and a consultant paediatrician, to support maternity make rapid and sustainable improvements to services.

The Womens and Childrens care group interacted with third-party providers including NHS Improvement to ensure the service was governed and managed appropriately to co-ordinate safe, person-centred care.

Due to concerns highlighted by HSIB, NHS Improvement and other third party agencies had been working with the care group to review and rationalise the governance structure. Consideration had been given to reducing time spent in meetings to release time to focus on developing an agreed vision and service development plan for the care group, underpinned by a workforce plan.

Quarterly external meetings were held with the HSIB and minutes confirmed that the board reported its oversight of the quality of care in the Womens and Childrens care group. Minutes confirmed that commissioners reviewed maternity dashboard data, and felt that during the reporting period data looked positive. Reviews had highlighted similar themes, although the leadership team could provide evidence of a safety culture with increasing serious incident reporting and learning from outcomes.

The Womens and Childrens care group senior management team met monthly. They had a strategy for continuous improvement in safety, which included an accountable leadership team that included consultants, midwives, and neonatologists. The team consisted of the head of midwifery, a consultant, the governance matron, the service manager and information lead. Minutes confirmed that meetings discussed, budgets, national targets, service delivery and activity.

Midwifery meetings were held at all levels, Matrons held monthly meetings to review services. Band 7 midwives within the unit and the community setting would hold meetings with each other to discuss staffing, implementation of new practice, compliance and future planned services.

The Womens and Childrens care group had created processes to cascade learning from outcomes, changes to practice and case reviews for all staff. These included, news-letters, internal emails to all staff and important updates at daily huddles, to make sure these were embedded in practice.

Managing risks, issues and performance

Leaders used systems to manage performance, however, these were not always effective in all areas of the service. Leaders did not always identify and escalate relevant risks and identify actions to reduce their impact. However, the service had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders had not always identified and escalated relevant risks or identified actions to reduce their impact. Our inspection noted that maternity managers failed to identify a lack of incident reporting and assessment of risk on the day care unit. There was a lack of audit of wait times for women attending day care and a for women delivery babies alone in the bereavement suite. Also, although staff audited patient records they failed to identify the lack of use of MEOWS score on the day care unit.

Following our inspection the trust provided assurance on improved oversight of antenatal services by the leadership team, and the service now recorded when women accessed the service. Staff were encouraged to complete an electronic incident reporting form for women waiting longer than one hour to be medically reviewed.

Risk was monitored through local and trust wide meetings. The care group provided a monthly quality and risk report which was reviewed monthly at the quality committee. Other than risks we identified on the maternity day care unit, we found risks on the risk register were consistent with the concerns shared by maternity staff and there were current plans to address identified risks such as the siting of Resuscitaire on the delivery suite, the lack of space on day care, and doctor recruitment issues. The maternity risk register was reviewed monthly to identify any issues within performance. Information from the review meetings were fed through into the trust risk and governance monthly meetings.

Requires improvement

Maternity

The systematic program for clinical and internal audit monitoring of quality, operational and financial processes, had been embedded into the care group. Doctors and midwives engaged with the program and collected data from internal digital systems.

The BESTT transformation program and a quality committee monitored and supported the transformation program against agreed key performance indicators. Project and trust meetings were held monthly.

The maternity serious incidents were reviewed at the serious incident panel. The chief nurse worked with the medical director to review and approve the final drafts of route cause analysis reports prior to submitting these to the Clinical Commissioning Group.

The service had plans to cope with unexpected events. Managers had standard operating procedures for major incidents. Potential risks were assessed when planning services. Strategies included notifications to staff and the public of bad weather or seasonal flu outbreaks, and managers created action plans and reviewed staffing levels.

Financial support was provided under a financial special measures program. Finances were monitored by third party agencies who supported the trust to purchase essential equipment and digital systems to improve the quality of care for women and their families.

Managing information

The service collected reliable data and analysed it most of the time. 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. However, data or notifications was not always submitted to external organisations as required.

The leadership team reviewed the quality of information it collected to improve performance. There were sufficient performance measures which were monitored and reported. The trust contributed to national data collection for MBRRACE-UK (Mother and Babies: Reducing Risk through Audits and Confidential Enquiries), ATAIN (Avoiding Term Admissions into Neonatal Units) and BESTT.

Quality and sustainability received sufficient coverage at relevant meetings at all levels, staff had sufficient access to information. The trust had a complex multi-layered system for managing information. Key staff were assigned to different work streams and were responsible for implementing, assessing and reviewing data, which was fed back to the trust board.

The care group were working with NHS digital to create a digital patient health record, that women could access on their smart phone or computer. The unit contributed to a national working party which was trialling aspects of the new digital healthcare records.

Consultants and matrons were responsible for ensuring that information used to monitor, manage and report quality and performance was accurate, valid and relevant. Actions plans were reviewed at weekly meetings across the unit.

Engagement

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

Leaders had improved engagement with staff, clinical engagement had been a priority and the care group acknowledged this needed to be strengthened to support the quality improvements and changes in ways of working. The triumvirate engaged with the consultant body for them to lead on developing the strategy and approach to consultant cover. The care group had a change in clinical leadership and worked with them to develop a safe sustainable consultant cover package. Through this engagement, questions were posed on the financial sustainability of 24 hour obstetric cover across the care group .

The chief nurse chaired a monthly ‘getting to good’ group where the care group discussed progress against their Care Quality Commission action plan.”

The trust engaged with external agencies and strategies had been put in place to improve services. Maternity reports were presented to the patient safety committee chaired by the chief nurse.

Requires improvement

Maternity

There were positive collaborative relationships with women and third party organisations. The stillbirth and neonatal death charity, SANDS, had worked closely with mothers and the trust to create the 'Twinkling Stars' bereavement suite, which was in line with best practice.

People's views and experiences were gathered and acted upon to shape future services. The leadership team met quarterly with the East Kent Maternity Voices Partnership to review women's feedback and concerns. These meetings provided updates from service users about their experiences and informed the development of maternity services.

The trust collected patient feedback at the end of their care. Women were issued with a friends and family feedback form which were either sent in via the post or collected by community midwives. Patient feedback was positive data confirmed that during the previous year, 97% of women had reported a positive experience during antenatal and postnatal care.

Managers involved staff in the planning and delivery of services throughout the unit. Staff told us the trust funded a staff survey on training needs to inform the future development of training. Managers introduced discharge co-ordinators to assist staff with the administrative aspect of discharging women from Folkestone ward.

Learning, continuous improvement and innovation

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

The Womens and Childrens care group had been the subject of national NHS scrutiny due to historic concerns about patient safety and the higher than average number of poor outcomes for new born babies. Pro-active consultants, doctors and midwives affected by the increased scrutiny reviewed current evidence and devised improvements to the continuous professional development of all maternity staff. These improvements were ongoing, and part of a three year redevelopment program designed to respond to public concerns, and reduce poor outcomes for the women and families of East Kent.

Continuous learning, improvement and innovation was encouraged and developed to improve care for women across the trust. Improvements in team working through a model of multi-disciplinary simulation training, using real incidents, was exemplary and mentioned in all the staff interviews. The unit adopted a multi-professional physiological approach to fetal heart monitoring led by a consultant at William Harvey Hospital.

There were standardised improvement tools and methods in place to review and improve evidence based practice which included the implementation of the BESTT program.

The trust had created The Faculty of Multi Professional Learning in Maternity in 2018 which contained stated of the art technology and equipment to support simulated learning in a multi-professional setting. Three practice development midwives supported by a consultant reviewed audits, planned and delivered training for a range of subjects.

The consultant had completed a global review of 30 international maternal inquiries to highlight quality maternity care across the world. They identified three themes: consistent language, reduced variations and formal leadership quality improvement and learning. Based on their research they introduced human factors training for all health care professionals involved in maternity care, designed to improve communication and actions during emergency situations.

The trust had reviewed the evidence and updated its practice for monitoring the fetal heart electronically. Maternity units cross-site adopted that the most up to date method of physiological interpretation of fetal wellbeing (cardiotachagraph) readings which was critical to reduce neonatal hypoxia during childbirth.

Maternity services introduced TRiM (Trauma Risk Management) in 2019. TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event. TRiM practitioners have completed training to understand the impact dealing with trauma has on staff, and employs strategies for staff to assimilate trauma. TRiM provides emotional support for staff who otherwise may not seek help after being involved with a traumatic event.

Outstanding practice and areas for improvement

Outstanding practice

- Midwives created a service to provide women with ear plugs on the postnatal ward to help them sleep.
- Kanga wraps were available for women who chose to breastfeed to optimise skin to skin care.
- The trust created a Faculty of Multi Professional Learning in Maternity, and invested in state of the art simulation equipment, which allowed all staff exposure to simulated 'real life' emergency situations.

Areas for improvement

Action the provider MUST take to improve

- The trust MUST ensure it assesses the risks to the health and safety of women receiving antenatal care and treatment. Regulation 12(2)(a)
- The trust MUST ensure that standard operating procedures, used within William Harvey Hospital day care, operate effectively. Regulation 17(1)
- The trust MUST ensure that it mitigates the risks associated with using a combination of paper and digital patient care records. Regulation 12(2)(b)

Action the provider SHOULD take to improve

- The trust SHOULD ensure it continues to monitor and mitigate any identified risks due to the siting of Resuscitaire on the delivery suite
- The trust SHOULD ensure that 85% of Doctors complete safeguarding training
- The trust SHOULD continue to monitor and audit antenatal day care admissions and wait times
- The trust SHOULD ensure that venous thromboembolism assessments are carried out to meet national targets
- The trust SHOULD ensure its ward security system maintains a secure environment to which access is restricted at all times
- The trust SHOULD consider its approach to supporting mother's to help babies to adapt to life outside the womb within the first hour of birth. Including monitoring the cause of neonatal readmissions under 10 days and reviewing the impact of deploying one midwife to manage the elective section surgical list
- The trust SHOULD consider assessing the number of planned attendances against the number of unplanned attendances to be able to respond to the demand on the service
- The trust SHOULD consider creating a dedicated perinatal mental health service for women in need of additional mental health support or specialist intervention in-line with NHS England's Perinatal Mental Health Care Pathways 2018 recommendations
- The service SHOULD consider its approach to promoting infant feeding conversations during pregnancy

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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