East Kent Hospitals University NHS Foundation Trust

Queen Elizabeth The Queen Mother Hospital

Inspection report

St Peter's Road
Margate
CT9 4AN
Tel: 01227766877
www.ekhuft.nhs.uk

Date of inspection visit: 10 to 11 January 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Queen Elizabeth The Queen Mother Hospital

Inadequate 

Our rating of this location went down. We rated it as inadequate because:

- Essential resuscitation equipment was not always placed to enable easy and rapid access. The service did not always control infection risk well and the environment and equipment was not always cleaned effectively. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always complete daily checks of specialist equipment and equipment was overdue safety checks and maintenance. Staff did not always manage clinical waste and sharps well.
- The service did not have adequate oversight of the risk of baby abduction. Records were not always stored securely and medicines were not always managed safely. Although the service managed safety incidents appropriately and learned lessons from them, staff could not tell us what these lessons were.
- Managers did not always monitor the effectiveness of the service in a timely way. Outcomes for women were not always positive, consistent or met expectations, such as national standards. Milk for babies was not always stored securely.
- Leaders did not always understand and manage the priorities and issues the service faced. Staff did not always understand the service's vision and values, and how to apply them in their work. Not all staff felt there were regular opportunities to meet to discuss risk and governance. Staff did not always know how to speak up if they had concerns. The service's information systems did not provide sufficient coverage of both quality and sustainability. The service did not have standardised quality improvement methods to drive improvement.

However:

- The service had enough staff to care for women and other pregnant people. Staff understood how to protect women and other pregnant people from abuse. Staff assessed risks to women and other pregnant people, acted on them and kept good care records. Staff were mostly up-to-date with required safety training.
- Staff worked well together for the benefit of women and other pregnant people, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated women and other pregnant people with compassion and kindness. They provided emotional support to women and other pregnant people, families and carers.
- The service planned care to meet the needs of local people, took account of women and other pregnant people's individual needs. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Most staff felt respected, supported and valued. They were focused on the needs of women and other pregnant people receiving care. The service engaged well with women and other pregnant people and the community to plan and manage services and all staff were committed to improving services continually.

Maternity

Inadequate 

East Kent University Hospitals NHS Foundation Trust is one of the largest hospital trusts in England, with five hospitals and community clinics serving a local population of around 695,000 people. The Trust provides local services primarily for the people living in Kent.

The Queen Elizabeth the Queen Mother Hospital (QEQM) is one of five hospitals that form part of East Kent University Hospitals NHS Foundation Trust. The maternity service at the QEQM hospital delivers approximately 2,500 to 3,000 babies each year. East Kent University Hospitals NHS Foundation Trust has another acute hospital with inpatient maternity services called the William Harvey Hospital.

The maternity service at the QEQM includes; St Nicholas' suite which is a daycare and antenatal clinic, St Peter's midwifery led unit, Kingsgate ward which is an antenatal and postnatal ward and the labour ward.

The service had one assessment room and three clinical rooms in St Nicholas' suite. These rooms were to triage and assess women and other pregnant people attending the clinic with concerns.

There were three birthing rooms, two with pools, in the St Peter's midwifery led unit.

Kingsgate ward had 21 beds. This consisted of 7 side rooms and 3 bays. Two of the bays had 5 beds and 1 bay had 4 beds.

The service has a 3-bedded induction bay; high risk inductions occurred on the labour ward. The labour ward had seven labour rooms for high risk women and other pregnant people to deliver their babies, one of these had a birthing pool. Two labour rooms had ensuite bathrooms and the rest had shared facilities. The labour ward had one theatre for emergencies during birth and a recovery room attached. Elective cesarean sections were completed in the main theatre for the hospital.

The service had a dedicated bereavement suite with an ensuite bathroom and kitchen facilities.

We carried out an unannounced comprehensive inspection of the maternity services at East Kent Hospitals University NHS Foundation Trust. We visited the maternity units at the QEQM hospital on 10 and 11 January 2023. We also visited the community midwifery services at Kent and Canterbury Hospital and Buckland Hospital.

To get to the heart of the women and other pregnant people's experience we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well-led. During the inspection, we needed to understand women and other pregnant people's journey and make sure that women, other pregnant people and babies were kept safe from harm and staff were supported with their training and decision making.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Maternity

Mandatory training

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

Staff were mostly up-to-date with their statutory and mandatory training. Data from the trust showed, 91% of staff had completed statutory training and 81% of staff had completed their mandatory training. There were some areas of training which needed to improve the completion rates on. Data also showed 69% of staff had completed infection prevention and control level 1 training, 76% had completed hand hygiene training and 88% had completed moving and handling training.

Midwifery and medical staff completed adult and neonatal resuscitation; however, staff were not always up-to-date with this training. The service had a completion rate of 90% for neonatal resuscitation and 72% for adult resuscitation. The service told us there had been challenges in capacity to deliver this training.

However, 91% of staff were up-to-date with fetal monitoring training. Staff who were not up-to-date with this training could not remove fetal monitoring equipment from the mother without a trained second person reviewing the monitoring results and agreeing with the decision being made.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training aligned to the Core Skills Training Framework outlined by Skills for Health. Topics covered included: manual handling, health and safety and infection control. Staff felt training was comprehensive and met their needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. The practice development midwife team monitored attendance to training. A week's block of training was built into the workforce planning to ensure all staff completed the full range of training including mandatory and midwifery elements. The practice development midwife administrator kept a training log and monitored staff training attendance. If staff did not show up to training, they were flagged to the ward leaders. However, manager oversight of training was not always effective because staff were not always up-to-date. The trust told us that training compliance was also low due to a combination of staffing levels and training capacity which had impacted on the overall compliance.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Staff completed mental health training yearly and learning disabilities and autism training was part of their equality and diversity training. The service had a 97% completion rate for equality and diversity training. Staff felt this training helped them support these individuals.

Safeguarding

Staff had training on how to recognise and report abuse however, not all staff were up-to-date with safeguarding training. Staff understood how to protect women from abuse.

Staff received training specific for their role on how to recognise and report abuse, but not all staff were up-to-date with training. Staff received training in safeguarding adults level 1, 2 and 3. Staff were 100% compliant with level 1 safeguarding adults however, 84% of staff were compliant with level 2 safeguarding adults and 72% of staff were compliant with level 3 safeguarding adults. The service told us it was predominantly medical staff who were non-compliant with safeguarding training.

Maternity

Staff had received training in child protection level 1, 2 and 3. All staff were compliant with level 1 training. However, 95% of staff were compliant with level 2 and 85% of staff were compliant with level 3 training. Staff also received level 1 and 2 Prevent training, which seeks to safeguard and support those most at risk of radicalisation. Staff had 100% compliance with level 1 training, however staff had 85% compliance with level 2 training. Midwives had safeguarding supervision sessions three to four times per year.

Staff knew how to recognise female genital mutilation (FGM), they were able to refer to a specialist consultant based at the Queen Elizabeth the Queen Mother Hospital and social services. Staff told us the referral process was easy to complete.

The trust maternity safeguarding team were based in Buckland Hospital. Midwives completed a maternity support form if there were safeguarding concerns and sent this to the safeguarding team for advice. We were told the safeguarding team did not update women's records with their advice, but this was returned to individual midwives for action.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated a good understanding of safeguarding and their responsibilities around safeguarding. Staff had a good understanding of who to inform if they had concerns. We saw follow-up support and care recorded in women's notes when they were highlighted as a safeguarding risk.

We observed safeguarding flow charts in staff offices to support them in the process for reporting concerns.

We observed patient safeguarding information displayed which included a number for patients to contact if they were concerned.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had a baby abduction policy. The maternity unit had a buzz-in system and cameras at the entrance. This meant the reception staff could control who entered the unit. Birthing partners wore pink wristbands to identify them and staff were encouraged to challenge individuals who were not wearing the wristband. The service had an infant and child abduction plan; however, this was past its review date of November 2022, but we were told this was currently under review.

The service did not have a system to control who exited the unit, which was a potential security risk. The service had not formally carried out a risk assessment in relation to this. We were not assured all risks had been considered and mitigations and control measures implemented to address potential risks. We reviewed the risk register and did not find an entry for this risk documented. We were told the service had plans to include a system to control who exited the unit in their next phase of estates work on the department. However, we could not see this included on the estates plan business case. Following the inspection, the trust told us they had identified the need for a risk assessment and had added it to their maternity action plan.

Cleanliness, infection control and hygiene

Infection risk was not managed consistently. Staff used equipment and control measures to protect women, themselves and others from infection. They kept the premises visibly clean. However, there were some areas which could not be cleaned effectively, which posed an infection risk and we saw some equipment was dusty. A few members of staff did not adhere to infection prevention and control principles.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. Ward areas in the maternity unit were generally clean and well maintained by the hospitals contracted domestic cleaning team. During our inspection, we observed domestic staff regularly cleaning the floor, bathrooms and birthing rooms. Furnishings

were wipe clean and intact with no damage. The unit was cluttered due to limited space and storage. We observed the corridors on the labour ward, midwifery led unit and Kingsgate ward had equipment, cots and a bed along the corridor. We observed storage boxes on the floor which meant the floor could not be cleaned effectively. This posed an infection prevention and control risk.

The unit generally had a lot of wear and tear in terms of estate. We observed damage to doors, floors and window ledges. We saw leaking roofs and doors bowed. These posed an infection prevention and control risk as they could not be cleaned effectively. We saw similar concerns in the community service environment at Kent and Canterbury Hospital.

In the patient bathroom in the antenatal care and triage area, we saw a shelf that was very rusty and toilets where the enamel had worn away. These items posed an infection prevention and control risk as they could not be cleaned effectively and more generally established a poor patient experience for women visiting the department.

Following our inspection, the trust told us they had completed an estates review of the department and raised a work request for the leaking roofs, bowed doors and the rusty shelf and toilets where the enamel had worn away in the patient bathrooms.

Kingsgate ward used single use curtains. We observed these had not always been changed recently. For example, we saw one curtain which covered a treatment area for newborn babies had not been changed since March 2022. Following our inspection, the trust provided us with a disposable curtain log, this outlined the date when the curtains were last changed and recorded if they were in date. The log showed the service had a 100% compliance with disposable curtains. Records we reviewed did not highlight the curtain we had raised concerns about as requiring replacement.

Cleaning records were not always up-to-date. Domestic staff completed daily checklists to demonstrate areas were cleaned. Cleaning records for the midwifery led unit and Kingsgate Ward were up-to-date. However, there were gaps in the cleaning records for the labour ward. For example, there were six days where the toilets and showers had not been signed off as cleaned.

Staff completed a checklist to demonstrate that the obstetric theatre was cleaned daily, we saw this checklist was complete. The service completed an audit of cleanliness, Kingsgate ward and the midwifery led unit had an overall compliance of 100% and the labour ward had 99% compliance. However, we found numerous equipment that was dusty, this included cots for newborn babies. We were told by domestic staff that cleaning equipment was the responsibility of the clinical team. We reviewed the equipment checklists which included cleaning and we saw gaps in these records. We also saw inconsistent use of green ‘I am clean’ stickers. For example, we saw one sticker with a recorded clean date of 21 November 2022 and a second entry on the same sticker for 22 November 2022.

We were told birthing pools were cleaned daily, there were whiteboards on the door of each room as a record of when it was last cleaned. We saw the pools had all been cleaned daily according to the whiteboards on both days of our inspection. However, we reviewed records for daily cleaning of birthing pools and there were gaps. For example, in December 2022 we saw no evidence of daily cleaning for 12 out of 31 days of the month. Compliance was better in November 2022; we saw gaps in only 3 out of 31 days; however, in October 2022 we saw gaps in 6 out of 31 days.

All reusable equipment was decontaminated onsite. Clean and dirty equipment was managed well and there was no cross contamination of equipment.

Staff generally followed infection control principles including the use of personal protective equipment (PPE). The maternity service provided staff with PPE to prevent and protect people from healthcare-associated infections. All staff

at the Queen Elizabeth the Queen Mother Hospital wore appropriate PPE for the care they were giving. We saw staff observe infection control principles for example, they were bare below the elbows and completed hand hygiene before patient contact. The service completed regular audits on hand hygiene and PPE use. The service had a 94% compliance rate with hand hygiene and PPE on Kingsgate ward and a 96% compliance on the labour ward.

We saw a number of staff in the community midwifery team who were not adhering to infection prevention and control principles. For example, we saw long hair not tied back, false nails, jewellery and they were not always bare below the elbows.

Following our inspection, we imposed conditions to ensure the service implements an effective system for assessing, managing and monitoring the safety of the environment and equipment at the maternity department. This included elements of infection prevention and control.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

During our inspection, we found fire safety was not well managed. The unit had three fire exit routes that staff could use. One of the fire exit routes was through the labour ward. We observed double doors which were labelled “Automatic fire door” with the automatic hinge removed. This meant the door would not close automatically in the event of a fire and does not meet the “Firecode – fire safety in the NHS HTM 05-03”. Fire doors did not have the time of safety displayed on the door; therefore, staff would not know how long they would be safe in that compartment.

The fire exit route through the labour ward was cluttered as a result of a lack of storage on the ward. This meant it would make the escape of women and babies on beds very difficult. Following the exit route further, staff and women would come to two exit options, however there was no green running man to direct staff and patients to safety. Furthermore, we observed numerous fire doors labelled “fire door keep shut” propped open or left open.

The service had fire risk assessments for each area of the maternity department which were in date. These reports identified concerns around ensuring escape routes were unobstructed.

Following our inspection, we raised concerns with the local fire department and with the trust. We received evidence that action was being taken to address the concerns found. For example, the missing green running man had now been installed. We also received evidence that the automatic hinge component had been removed and was due to be reinstalled. Following the inspection, the service completed a fire risk assessment on every door, ensuring they had the correct labelling. The service told us they were going to complete ward rounds three times a day to check compliance of doors with fire safety. We were told this data would be reported monthly to the maternity and neonatal quality assurance group. We also received information that the local fire department had attended the site to complete a review.

The environment was not wholly suitable for the delivery of services. The trust was very aware that significant investment was required to improve various areas. A business case and improvement strategy outlined the necessary work and what capital would be needed for this. Phase 1 of the improvement plans had been agreed and we saw information to indicate what works would be undertaken.

Maternity

The design of the environment did not follow national guidance. The environment layout was not in line with health building notes best practice guidance HBN 09-02 for maternity care facilities. Labour rooms were small, which meant that lifesaving equipment such as resuscitaires could not be present in all rooms. One member of staff described this as "chaotic when managing obstetric emergencies. Babies are carried by hand across the corridor to be resuscitated. Partners are pushed aside in emergencies."

The service had a risk register entry about the size of labour rooms not being able to facilitate resuscitaires. The risk register entry had the recorded mitigation: "The equipment is placed in a safe environment to maintain privacy and dignity during the resuscitation procedure." During our inspection we found this was not always the case as resuscitaires were in the corridor and we were told staff would take the baby to these.

The service sent us a risk assessment, which outlined the risk and what mitigating actions the service had in place. It also included consideration of other resuscitation options such as a bedside resuscitaire, although the trust felt this posed a tripping hazard.

Following the inspection, the service developed a standard operating procedure (SOP) to ensure newborn babies are identifiable if separated from parents during neonatal resuscitation. Actions in this SOP included tagging the baby before it being taken to a resuscitaire, taking the birthing partner with them to the resuscitaire and transporting the baby in a cot to the resuscitaire. However, these initiatives were unrealistic in the event of a time critical emergency resuscitation of a newborn baby where seconds counted.

The service did not have enough suitable equipment to help them to safely care for women and babies. Suction was not present in all rooms on the labour ward. The service had one portable suction unit on the adult resuscitation trolley in the event of an emergency. This was a risk in the event of more than one woman needing suction at the same time. This was recorded on the maternity risk register under the risk titled "Inadequate estates within maternity at EKHUFT". There were no specific mitigations or actions in relation to suction.

The service did not have enough resuscitaires for each room on the labour ward. This was a risk in the event of numerous newborn babies needing more intensive care at the same time.

Following our inspection, we asked the trust to take action relating to the safety of women and babies within the labour wards because neonatal resuscitation equipment was not available to use at the bedside and the limited availability of adult resuscitation equipment. In response the trust confirmed they had increased access to portable suction units and now had one in every labour suite. However, they confirmed resuscitaires were not able to be accommodated in labour rooms due to the size of the labour rooms. The service have moved resuscitaires from the midwifery led unit to the labour ward to increase the availability of resuscitaires. Additional resuscitaires were being urgently procured in order to open the midwifery led unit again, but as a standard labour room.

Women did not have ensuite bathroom facilities, some rooms had Jack-and-Jill shared ensuites and some rooms had no bathroom at all. This meant women would have to walk down the corridor during labour and post-birth to use the bathroom. This was a poor experience for women in terms of patient dignity.

There was limited space in the postnatal ward for paediatric checks. Staff told us they completed paediatric checks in a "treatment room", which was essentially a treatment space off the main corridor. This area was small and a resuscitaire

was present, which meant the curtain could not be drawn around the newborn baby for their privacy. This was also an infection prevention and control risk as the curtain could not be drawn on what was a busy corridor. During our inspection we observed staff cannulating a baby in this area. We were told following our inspection that the service had moved the paediatric checks to a new designated room. We saw picture evidence of the designated room.

In the antenatal clinic and triage area, there was a hydration station for women attending with hyperemesis (severe or prolonged vomiting). This area was next to store cupboards with a screen. This area did not provide women with privacy or dignity as any discussions between women and staff could be overheard by people in the waiting area.

The service had one obstetric theatre on the labour ward. This meant women had to be prioritised based on level of need. The availability of a second theatre was in the main theatres and was not dedicated and is coordinated with the elective list as well as CEPOD (confidential enquiry into perioperative deaths) activity. Staff were proactive in reviewing the case load and assembling a theatre team at the main theatre ahead of a potential emergency. The journey to the main theatre from the maternity unit took on average five minutes, but this was through the main corridors of the hospital. This was a poor patient experience for women. The service had identified this as a risk, and it was on their maternity risk register with mitigating actions. Mitigations included monitoring the number of elective caesarean sections daily to make adjustments accordingly based on emergency demand.

Staff described availability of certain equipment not being suitable. For example, between the triage and antenatal department, labour ward, midwifery led unit and the postnatal ward, they had one bedside scanner. This affected staff daily as they had to find the equipment when needed and had a risk of delaying the safe review of women and babies.

Staff did not always carry out daily safety checks of specialist equipment. The adult resuscitation trolley specialist equipment was not checked on a daily basis. We reviewed the record and found that in December 2022, on 18 out of 31 days, the resuscitation trolley was not checked. However, we checked resuscitaires and their daily checklists were complete. The service monitored overall compliance with daily checks of specialist equipment such as neonatal resuscitaires, adult resus trolleys and emergency trolleys. However, information provided by the trust showed this was incomplete between the week commencing 15 August 2022 to week commencing 22 January 2023. There was no assurance of oversight of compliance in this area.

During our inspection of the community midwife teams at Buckland Hospital, we observed that the adult resuscitation trolley was not checked on a daily basis. For example, there were two whole weeks in November 2022 where checks had not been carried out.

We saw four out of date consumables on the emergency trolley in the midwifery led unit, despite records indicating the trolley had a full check recently. There was no assurance the checks completed were identifying expired pieces of equipment and actions taken as necessary.

During our inspection, we found some equipment which was overdue its maintenance. Equipment included a sonicaid (a hand-held monitor used to detect fetal heart rate) and a cot warmer. The service told us they had a trust wide asset management system to help monitor the location of medical devices and their maintenance schedule. However, this did not always appear to be effective. We reviewed the equipment asset log and of 390 items on the log, 52 were overdue their maintenance checks. These items included Cardiotocography (CTG) monitors, fetal monitoring sonicaids and resuscitaires.

Maternity

The service did not always have suitable facilities to meet the needs of women's families. The service had visitor toilets that women's families could use. The service had access to drinks and snacks for women's families to have. However, there were no comfortable facilities for birthing partners to stay overnight and they would have to sleep on chairs. Families told us this was uncomfortable.

The trust had a waste management policy, which was out of date. This included segregation of waste, control of substances hazardous to health (COSHH) and sharps. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Generally, we saw waste was disposed of safely.

Sharps, such as needles, were generally disposed of in line with national guidance. However, we found one sharps bin unlabelled.

Generally, controls were in place for substances subject to COSHH requirements. Cleaning equipment was stored securely in locked cupboards. However, we did observe one disinfectant spray on the epidural trolley.

Women could reach call bells and staff responded quickly when called. The service had call bells for women in the ward areas. Women could reach these call bells and we observed staff respond to call bells promptly. Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring the safety of the environment and equipment at the maternity department.

Assessing and responding to patient risk

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

Staff completed risk assessments for each woman on arrival, using a recognised tool, and reviewed this regularly. The triage service had implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS) and we observed this process was working well in the department. A band 7 midwife saw women within 15 minutes of arrival to assess them. Women were scored using a red, amber and green system (RAG). If a woman was RAG rated as red, they would be transferred straight onto the labour ward for monitoring. The triage team had one midwife allocated to answering telephone triage calls at all times.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used maternal early obstetric warning system (MEOWS) charts to identify women at risk of deterioration. We reviewed five MEOWS charts during the inspection and found them to be correctly completed and concerns had been escalated to senior staff. The service had completed an audit of MEOWS chart compliance which showed 69% of applicable observations were recorded, with an overall completion rate of 90%. We also saw neonatal observations for babies born by caesarean section recorded in patient notes. These were comprehensive and complete.

Staff described how they would respond to a medical emergency. Staff completed scenario training (PROMPT) yearly. During the pandemic, the training had been delivered virtually and the trust acknowledged that learning was limited compared to practical in-person delivery of emergency skills training. We observed a medical emergency during our inspection and staff carried out a prompt handover of concerns. We observed the crash team attend the ward in a timely manner as a baby was not crying following an emergency caesarean section. The emergency was managed in a timely manner and the mother and baby had a good outcome.

Staff completed fetal heart monitoring where required. The service audited the completion of fresh eyes/ears which was occurring 87% of the time. When staff suspected hypoxia, they escalated this concern to medical staff. The service

audited compliance with escalation and the most recent results showed 100% compliance. The service had a risk register entry regarding the potential for misinterpretation of cardiotocograph (CTG) by staff. CTG is a technique used to monitor fetal heartbeat and uterine contractions during pregnancy and labour. The service had mitigating controls which included all staff to complete yearly CTG training and have 3 assessments of competency each year.

Staff knew about and dealt with any specific risk issues. The service monitored women's venous thromboembolism (VTE) risk regularly. For example, they completed a VTE risk assessment at booking, at any and each antenatal admission, at delivery, postnatally and at discharge. The service used the sepsis six bundle in triage to identify presenting women's risk of sepsis. We saw glucose monitoring in five patient records we reviewed, along with carbon dioxide monitoring.

Community midwives who ran antenatal clinics completed a number of routine tests, according to the woman's stage of pregnancy. For example, these included carbon monoxide monitoring, blood pressure and fetal movement. Women were reminded and encouraged to get vaccinated against whooping cough and flu. Women had screening for genetic anomalies. The service had a fail-safe clerk who ensured all women received their results for genetic screening.

Records showed swab counts were recorded as completed and signed by two professionals. The service completed an audit to monitor compliance with WHO surgical safety checklists, on average compliance was 98% in the last quarter.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had mental health midwives and staff told us they were easily contactable and responsive when they needed their advice. We saw mental health concerns documented in patient records.

Staff shared key information to keep women safe when handing over their care to others. Where women had additional needs, staff completed baby alert forms and maternity support forms to ensure all staff know of the patient history, current support they were getting and support during and after birth.

Midwifery staffing

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

The service had enough nursing and midwifery staff to keep women and babies safe. The service used a nationally recognised staffing acuity tool called Birthrate plus. This recorded any red flags or areas of concern within staffing data. The service also monitored 1 to 1 care in labour and whether relevant staff maintained their supernumerary role, as indicators of safe staffing. The service had an average rate of 100% for 1 to 1 care in labour and a 99% average for staff maintaining their supernumerary role.

The service had a risk register entry named "Lack of Midwifery workforce availability due to ongoing high levels of maternity leave and vacancies" with mitigating actions. These included a 10am situation report meeting to review staffing levels daily.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily

according to the needs of women. Leaders planned the rota eight weeks in advance, taking into account staffing levels and skill mix according to guidance. The ward manager was able to adjust staffing levels based on the acuity of women on the day and request bank shifts for those who haven't been filled. We were told that occasionally the ward leader might have to act in a clinical capacity when staffing was pressured.

The number of midwives and healthcare assistants matched the planned numbers. However, some staff told us they felt the department was short staffed sometimes. The department had a high rate of short-term sickness over the holiday period in December 2022. The service did not display planned versus actual staffing on any of the ward areas.

The service had low vacancy rates. The service currently had no vacancies for midwifery staffing.

The service had low turnover rates. The service currently had a 2.6% turnover rate. Staff said they were happy working in the department and could not recall people leaving other than to retire.

The service had low sickness rates. The service currently had a sickness rate of 4.8%.

The service had low rates of bank and no use of agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used bank staff to support staffing. These were often staff already working for the midwifery service who were taking on additional shifts. This meant they were familiar with the service. The service did not use agency staff.

Managers made sure all bank staff had a full induction and understood the service. All bank staff had to complete mandatory training and completed an induction before working for the midwifery service. Staff told us they felt this met their needs.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. Managers could access locums when they needed additional medical staff. The medical staff matched the planned number. The service had 16 consultants in total. This included: 11 substantive consultants who also cover the on-call rota, 2 consultants to do the elective surgery lists and 3 locum consultants. Locum consultants were available when they needed additional staff.

The service always had a consultant on call during evenings and weekends. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service had consultant cover between 8am to 5pm by two consultants and 5pm to 10pm as a twilight shift. One of the two consultants was dedicated to the labour ward. After 10pm there was an on-call rota. Staff told us the majority of consultants sleep at the hospital, so they were easily available. During the night, the department had medical support from one middle grade doctor and 2 junior doctors. During the weekends the service had consultant cover between 8am to 8pm.

The service had low vacancy rates for medical staff. The service currently had vacancies for 3 consultants and 2 registrars.

The service had low turnover rates for medical staff. The service currently had a 2.6% turnover rate.

Sickness rates for medical staff were low. The service currently had a sickness rate of 4.8%.

The service had low rates of bank and locum staff. Managers made sure locums had a full induction to the service before they started work. Staff told us they had a comprehensive induction before they started work on the maternity unit.

Records

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

Women's notes were comprehensive and all staff could access them easily. We reviewed five sets of paper patient records on the ward. They were clear, up-to-date and included comprehensive details of women's care and treatment. For example, we saw follow-up support and care recorded in women's notes when they were highlighted as a safeguarding risk and we saw mental health concerns documented.

The service completed an audit of patient records in 2021. The audit found 25% of admission and 48% of labour ward admission 'SBAR' tools were completed in full. SBAR stands for situation, background, assessment and recommendation and it is a tool which is commonly used during the handover of care for patients. The service had set an action to explore the barriers which prevented SBARs being used for antenatal admission.

The audit also found 43% of records had an admission assessment tool completed for intermittent auscultation (IA) and 29% recorded fresh ears stickers every two hours. The service had set an action to promote the use of IA assessment tool for all women.

The service also found a decrease in the essentials of record keeping such as entries being legible, signed and dated. The service had set an action to improve the essential requirements of record keeping.

When women transferred to a new team, there were no delays in staff accessing their records. Patient notes were paper based and present on the midwifery unit, therefore there were no delays in staff accessing their records. Patient records from triage were on paper, then transferred electronically so all staff had access to them.

Records were not always stored securely. During our inspection we saw a postnatal records cupboard open numerous times. We raised this with staff on a number of occasions but continued to see this record store open. However, electronic records were stored securely as the electronic systems were protected with individual passwords.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines. The monitoring of FP10s was not effective and the pharmacy service only provided a limited service to the unit. FP10s are prescription stationery whereby patients can take the prescription to a community pharmacy for dispensing. Maternity staff received training in administration of medicines and intravenous drugs.

Maternity staff reviewed each women's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff provided a 'desk visit' to the maternity unit. Pharmacy staff reviewed women's medicines when requested by maternity staff and screened the medicines section of discharge summaries. Therefore, the consistency of prescribing and advice lacked adequate pharmacy oversight.

Staff told us some women were discharged without their discharge medicines as they were not available at the point of discharge and family members had to return to the unit later to collect these medicines. Therefore, we were not assured the discharge process was effective or timely for these women and their families.

Staff did not always complete medicines records accurately and keep them up-to-date. None of the medicines charts we reviewed had the patient's details on the IV fluids section, where there was a space for the address.

Staff did not always store and manage all medicines and prescribing documents safely. The process for monitoring the use of FP10 prescriptions was not effective, as it did not highlight unaccounted for FP10 prescriptions. Kingsgate Ward lacked enough work surfaces and space for staff to manage medicines safely. Therefore, we were not assured that medicines were always safely prepared for administration and associated stationery were accounted for.

During our inspection we found to take out (TTO) medicines were not always stored securely. For example, we found TTO medicines in the midwives' office table and the office was not locked. We were told the porters bring the medicines and place them in the midwifes' office until the patient goes home.

We found some out of date medicines at Buckland Hospital. For example, we found medicines that had expired in July 2022 and December 2022.

Community midwives kept medicines required for homebirths in their car. We reviewed these bags and they were well organised. The on-call midwife checked homebirth bags and nitrous oxide with oxygen cylinders weekly. At Buckland Hospital, the nitrous oxide with oxygen cylinders were collected by a midwife on their way to attend a homebirth. We were told this was difficult at night as they had to get security to open the unit, and this caused a delay.

Incidents

The service generally managed safety incidents. Staff recognised and reported incidents and near misses. Managers ensured that actions from patient safety alerts were monitored. Managers investigated incidents and shared lessons learned with the whole team. However, staff told us they were sometimes too busy to read about lessons learnt from incidents and staff could not tell us recent learning from incidents. Some risks and practices were normalised, which meant staff might not identify these as incidents and report them.

Staff knew what incidents to report and how to report them. The trust had an incident management policy, which provided staff with support around reporting, categorising and investigating incidents. Staff understood how to report incidents through their online reporting system and had a good reporting culture. We reviewed incidents reported by staff and found them thorough and complete. Staff were supported by a band 6 patient safety midwife. However, we were concerned that there were risks in the service they had not identified and some practices were normalised, which meant staff would not be identifying these as incidents and reporting them. For example, due to lack of space for neonatal checks, they were occurring in a bed off the corridor. This was an infection risk which had not been identified by the service and normalised practice by the staff.

The service monitored incidents to look for themes and trends. Trends included postnatal readmissions due to wound infection, continued staffing challenges leading to diverts of patients from the William Harvey Hospital to the Queen Elizabeth the Queen Mother Hospital, number of 3rd and 4th degree tears and postpartum haemorrhage above 1.5 litres. The service had seen an increase in postnatal readmission and had agreed a deep dive to investigate this trend and identify any learning and potential improvements.

Maternity

The service had no never events on any wards. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm, or death has occurred in the past and is easily recognisable and clearly defined.

Staff reported serious incidents clearly and in line with trust policy. The service had a rapid review incident panel which occurred three times a week. This was held to discuss incidents where there were concerns of potential serious harms. We observed one of these panels which was multidisciplinary and had good challenge. The group discussed incidents that had occurred that week or the week before to determine immediate learning actions and the type of investigation required. The service had identified areas for improvement as a result of learning from rapid reviews for example, greater teamwork during postpartum haemorrhage.

Serious incidents (SI) went to an SI panel for appropriate investigation and sign-off. The SI panel was chaired by the Chief Nursing and Midwifery Officer, who with the Chief Medical Officer and Director of Quality Governance provided executive oversight and an opportunity to ensure immediate safety actions had been taken. The service had 44 open SIs currently awaiting investigation completion, 22 of which had investigation reports with the local integrated care board (ICB). Four of these investigations were not currently due and the rest had agreed extension dates. We did not feel assured safety concerns identified through SI investigations were consistently identified or addressed quickly enough. Learning from SIs was discussed at the Maternity and Neonatal Assurance Group and reported to the Quality and Safety Committee, and directly to the Board of Directors every quarter.

Serious incidents which met the relevant criteria were reported to the Healthcare Safety Investigation Branch (HSIB). We were told there was a backlog in implementing the action plans as a result of these investigations. The service had developed a process to ensure ongoing oversight of completion of action plans.

With support from an NHS Improvement Maternity Improvement Advisor for Midwifery, the service completed a thematic analysis of historic HSIB cases. This was used to create a thematic report with 68 actions as a result, which they had linked to the wider maternity improvement plan. We saw learning from HSIB reports was included on the services message of the week.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff understood the duty of candour and what it meant in their role. We saw duty of candour completed in incidents we reviewed. The service had a duty of candour dashboard to monitor compliance with duty of candour requirements.

We were told staff received feedback from investigation of incidents. However, staff could not tell us recent incidents in the department and learning from incidents. We saw staff received feedback from incidents through the service's message of the week to all staff. We were told the message of the week was discussed during handover in the morning. However, staff told us they were too busy to read the message of the week and the staff we spoke with during the inspection could not tell us about recent incidents and any learning from incidents. Despite this, we did see evidence that changes had been made as a result of feedback. For example, the service recently identified a trend in the number of incidents where babies had fallen out of beds as a result of parents co-sleeping with them. As a result, the trust had completed a deep-dive review of the incidents to identify any causative factors. The ward leader then sent an email to the midwifery team with information on interventions to mitigate the risk of any further falls. This included information about safe sleeping and bed positioning. We also saw information on the service's message of the week. The service had since seen a reduction in incidents following this action.

Maternity

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Incidents were investigated by the ward leader. All staff who completed incident investigations had access to specific training such as duty of candour, human factors and the incident investigation process. Women and families were involved in the investigation and the service held discussions with them.

Managers debriefed and supported staff after any serious incident. Staff told us they received a debrief after serious incidents and this included all medical emergencies.

Managers ensured actions from patient safety alerts were monitored. The service had a dashboard to monitor open or overdue actions from patient safety alerts.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, guidelines were not always up-to-date. Managers checked to make sure staff followed guidance through audits, however this was not always timely. Staff protected the rights of women subject to the Mental Health Act 1983.

The service had a range of policies and guidelines for staff to follow. Staff followed these to plan and deliver care according to evidence-based practice and national guidance, however these were not always up-to-date. The trust told us they had a plan to ensure guidelines were up-to-date by February 2023. We were sent evidence of the guidelines they needed to update and progression against the plan. For example, they had 38 guidelines out of date, 12 of which had their completed review and a further 10 were in the final stages of their review. The remaining 16 guidelines were overdue a review. Guidelines were discussed during the risk and governance meetings.

We saw patients receiving care in line with evidence-based practice and national guidance. For example, all women with risk factors for gestational diabetes were identified and offered glucose tolerance testing in line with national guidance.

The service had a clinical audit program to monitor staff compliance with the latest guidance. These included: diabetes, reduced fetal movement, and record keeping. We reviewed the trust audit program and saw that 35 out of 59 audits were flagged as being ‘behind schedule’ or ‘behind schedule, plan in place’. There was a risk women were not receiving care in line with best practice guidance as the service was not always monitoring compliance with latest guidance or identifying any concerns through audits in a timely way.

Any audits that were completed and had come out as non-compliant had actions and learning identified. For example, the trust had completed an audit of use of the SBAR tool. As a result, the service had created an action plan which included “Request the opportunity to deliver refresher to maternity staff on correct use of SBAR handover at all points of care to improve overall uptake, compliance and uniformity between sites.”.

Maternity

The service monitored the timeliness of newborn and infant physical examination against the NHS newborn and infant physical examination (NIPE) screening programme. Where the 72 hour screen of a newborn was delayed, the service identified the cause. The majority of causes were “Too ill for NIPE screen within 72 hours” (this was 62 out of 81 cases), only one out of 81 cases was cited as due to lack of staffing.

The service audited the effectiveness of the new triage system using Birmingham Symptom Specific Obstetric Triage System (BSOTS). We saw that 100% of calls were entered into the electronic system for auditing. They audited to look at the number of women with their RAG rating recorded and their reason for attendance to triage. For example, bleeding, abdominal pain or reduced fetal movement. They also recorded if the time to be seen had breached and what the reasons for this were. Learning was identified through the incident reporting process for breaches.

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

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. However, milk for babies was not always stored securely.

We observed that expressed milk was labelled and dated correctly in the designated fridge. Staff completed records on the room temperature and fridge temperature where milk was stored. We saw these records were complete. However, we found that the room to the fridge was not locked and the fridge and freezer were not locked. Staff told us this was never locked. We spoke with the head of midwifery who told us there should be a lock on the fridge for milk storage at all times. They replaced the lock on the fridge at the time of inspection after we raised concerns.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The service had water jugs available for women and their families and food was regularly offered to women. However, women were not able to access a kitchen or a drinks machine on the labour ward and postnatal ward. This feedback was also raised through “6 week After Care” calls. In response to this, the service had agreed for water coolers to be installed, although they had not been installed at the time of the inspection.

The service had a small kitchen on the midwifery led unit for women to use, however the environment was not inviting, and it was not clear if women had access to this. We observed the kitchen on the labour ward was small and did not have enough storage space. We observed trolleys stored against the wall opposite the kitchen with water jugs, cups and wrapped biscuits.

Staff fully and accurately completed women's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. These records were stored on the women’s paper based records. We did not observe any woman requiring this type of observation during our inspection.

Mothers had support from an infant feeding specialist. However, this cover was currently four days a week on the postnatal ward. We were told they had just appointed another infant feeding specialist which would mean they could offer six days a week for support. Women were supported at home by a community infant feeding specialist. The infant feeding specialist provided advice and support on breast feeding and bottle feeding. However, we observed there were no private rooms on the postnatal ward for women to feed their babies.

Maternity

Pain relief

Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women received pain relief soon after requesting it. Pain relief such as nitrous oxide (gas and air), epidural and oral pain relief was available. Staff told us there were no problems in obtaining pain relief or other medicines for women. All the women we spoke with told us they had received pain relief as required.

Staff prescribed, administered and recorded pain relief accurately. We saw pain relief was timely and recorded in patient notes.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, outcomes for women were not always positive.

The trust participated in the 2021 National Maternity Dashboard audit and submitted data to the required standard. The trust performed worse than the national average on a number of indicators. For example, the trust had a neonatal mortality rate of 1.6 per 1,000 compared to the national average of 1.5. The trust had a stillbirth rate of 3.8 per 1,000 compared to the national average of 3.3. The trust had a feeding support and encouragement score of 49.3 compared to the national average of 63.3.

The trust performed better than the national average on a number of indicators. For example, women who received a 3rd or 4th degree tear at delivery per 100 was 2.8 compared to a national average of 3.1. The trust had a rate of 2.0 compared to the national average of 2.8 women who had a postpartum haemorrhage of more than 1500ml per 100 deliveries. The trust had a 79.2 score compared to the national average of 78.7 for their response to concerns during labour and birth.

The trust participated in the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) audit. This found that the trust performed much worse than the national average for perinatal mortality rate.

The trust also participated in National Neonatal Audit Programme (NNAP). This audit found that the trust performed the same or better than the national average for all indicators.

The service used the National Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard. We reviewed PMRT documents which formed the agenda for the multidisciplinary team meeting to discuss mortality. We saw these meetings were well attended.

Managers and staff used the results to improve women's outcomes. The service had a maternity dashboard which included patient outcome indicators. For example, spontaneous vaginal delivery rate, category 1 section occurring in less than 30 minutes, induction rate and 3rd and 4th degree tears. The maternity dashboard was reviewed monthly in the maternity and neonatal assurance group.

In the January 2023 dashboard, the trust was showing to be worse than expected for 4th degree tears and Robson Group 1 caesarean rate. Robson's is a classification system for all deliveries. The service used this information to improve women's outcomes. For example, 3rd and 4th degree tears were discussed at the rapid review incident group and the service told us there were no significant themes. A local audit had been commissioned to review and identify if there was any learning.

The service monitored the number of transfers to the labour ward during and after a homebirth. The service had a higher than average rate of transfers during a homebirth while the mother was in labour. The service also monitored the number of transfers from the midwifery led unit to the labour ward during or after labour, this was not flagged as a concern for the service.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. The service participated in national audits and local audits to measure improvement over time. Audit results were reported via the maternity dashboard. Learning from audits was communicated in the message of the week.

The service was working towards a level two status against the Baby Friendly Initiative. The Baby Friendly standards provide services with a roadmap for transforming care. They have a staged accreditation programme which aims to enable services to support families with feeding and help parents build a close and loving relationship with their baby.

Competent staff

The service made sure staff were competent for their roles. However, not all staff were up-to-date with training. 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. Staff received any specialist training for their role, however they were not always up-to-date. For example, staff had access to practical obstetric multi-professional training (PROMPT), however not all staff had completed this training. The service had an 85% completion rate. The service acknowledged they had challenges with delivery of PROMPT training due to staffing pressures.

The service offered specialist training for their role, for example fetal monitoring training and neonatal life support. Staff had training in medical emergencies and trained together as a multi-professional team. Staff received training on infant feeding and tongue tie support from specialist midwives.

The service ensured staff completed five assessments each year with the maternity moving and handling link assessors which included evacuation from a birthing pool. The maternity team had completed 660 manual handling competencies in the last year and this included 117 scenarios where staff had to evacuate from a birthing pool.

Managers gave all new staff a full induction tailored to their role before they started work. Before all staff joined the service they were given an induction, this included bank staff. Staff told us the induction was comprehensive and met their needs.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service had an 87% completion rate for yearly appraisals. All staff we spoke with in the community midwifery team had received an annual appraisal.

The clinical educators supported the learning and development needs of staff. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The

service had three clinical skills facilitators who met with each individual on a preceptorship program, after each rotation. This discussion was focused on objectives and learning needs for that individual and gave them time to develop their skills. Newly qualified staff were given a competency pack and competencies were signed off by an experienced individual when staff could demonstrate their skills. Staff told us the clinical skills facilitators were very supportive.

The service had currently only one practice development midwife however, an additional three midwifes have been recently hired.

Managers identified poor staff performance promptly and supported staff to improve. Managers reviewed training and staff performance as part of the maternity dashboard and this was discussed in the monthly maternity and neonatal assurance group. Actions were identified to support staff to improve, for example the service was focusing on infection prevention and control.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. To ensure staff were not left without vital updates, information was shared with staff through other communication methods including private social media groups, emails and newsletters. However, staff told us they did not always have time to read information.

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 patients and improve their care. The service had regular meetings throughout the day to discuss patients and improve their care. We observed a patient safety huddle which included attendance from the special care baby unit, maternity matrons, consultant obstetricians, anaesthetists and operational managers. This was a multidisciplinary approach and discussed women and babies, including risks or concerns.

We observed all staff working well as a team to ensure women had safe care and treatment. Staff described good working relationships with all members of the clinical team including midwives, midwifery care assistants, obstetricians and anaesthetists. During the inspection we observed positive and supportive interactions within the multidisciplinary team.

Staff worked across health care disciplines when required to care for patients. The service had good links for mothers and babies requiring transitional care. Staff reported good joint working relationships between the maternity and neonatal staff.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants. Staff could call for support from doctors and other disciplines 24 hours a day, seven days a week. The labour ward, maternity led unit, antenatal and postnatal wards were available 24 hours a day, seven days a week. The service had medical staff presence on the wards between 8am to 10pm during the weekdays and 8am to 8:30pm at the weekends. The service had an on call rota to cover the times when medical staff were not present on the wards.

Maternity

The triage service was open 24 hours a day, seven days a week. The triage phone line was covered by a midwife 24 hours a day, seven days a week. Day care services were covered by midwives between 7:30am to 8:30pm seven days a week. Antenatal clinics ran between Monday to Friday to support timely care.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We observed information boards on the wards which included information on infant feeding, baby milk and “Don’t drop the Baby”.

We also saw mothers were sent home with information envelopes, these contained information and advice on postnatal exercises, contraceptives after birth and jaundice.

The service had numerous information documents on their website for mothers to access. These could also be requested in different languages, braille, large font and easy read. These documents included “Foetal Alcohol Spectrum Disorders Awareness”, “Infant crying and how to cope” and “Smoking during pregnancy”.

Staff assessed each woman’s health records when admitted and provided support for any individual needs to live a healthier lifestyle. Staff gave health promotion advice to women on various topics which was observed in patients records we reviewed. This included smoking cessation, breastfeeding, safer sleep, vitamin D and emotional wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff understood capacity and had support from mental health specialist midwives on the wards and in the antenatal clinics. Staff were aware of women’s wishes, culture and traditions as part of their birth plan and when women could not give consent, for example, in an emergency, staff made decisions in their best interest taking these wishes into account.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records. The service had actions from audits such as “Audit into Laparoscopy Consent and Procedure, with a Focus on Complications”, to ensure all relevant information was included on the consent form. This supported women to consent to care and treatment based on all the information available.

In two of the patient records we reviewed, we saw consent for a surgical procedure was completed and clearly documented in line with guidance. However, the service did not audit completion of consent documentation. Therefore, they did not know the extent to which staff were completing these documents effectively with women.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff used mental health assessments to determine women’s mental health risk. We saw these completed in patient records. Staff could describe who to contact for advice and support for patients experiencing ill mental health.

Maternity

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated women with compassion and kindness and took account of their individual needs. Women's privacy and dignity was at times compromised when receiving care.

During inspection we found that women's privacy and dignity were compromised. For example, we found issues with the environment such as lack of ensuite bathrooms on the labour suite, this meant not all women had complete privacy during or following labour.

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. We observed interactions with women and their partners and staff were friendly and compassionate. We saw call bells answered in a timely manner and staff took the time to talk to women.

Women said staff treated them well and with kindness. For example, a woman told us staff supported them with breastfeeding and therefore they felt happy to go home. Feedback from women included, "We notice the passion, expertise, teamwork and pure heartedness of the lovely midwives" and "The level of care from the majority of doctors and all of the midwives was absolutely amazing, always helpful with a warm and welcoming attitude".

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 ill health. Staff were considerate and treated women with kindness when they had additional mental health or complex needs. We saw empathy demonstrated when women were upset, and practical support offered when appropriate.

Midwifery staff told us they involved women in planning their care. Staff completed maternity support forms to ensure appropriate referrals were made. Maternity support forms included patient history information and any relevant services who may need to be involved such as the mental health midwifery team or social services. We saw evidence of this in patient records. This meant women received person-centred care.

Emotional support

Staff provided emotional support to women and families. However, some of the standardised practices in the labour suite had the potential to cause distress.

The limitations of the environment on the labour suite meant that babies requiring emergency resuscitation were separated from their mother. Babies were taken to a nearby resuscitaire which could have been outside of the labour room. Staff had not considered the emotional impact for the mother of removing their baby in a highly stressful situation.

Staff gave women and those close to them help, emotional support and advice when they needed it. Counselling services were available for women and they could be signposted to this as needed. We saw positive feedback from women who said they were very grateful for the care and emotional support they received from staff.

Maternity

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. We saw privacy screens used and we were told women who might become distressed were cared for in single rooms for a quieter and more private environment. The environment in some parts of the maternity unit, meant that privacy and dignity for women was not always able to be maintained.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they felt supported in having difficult conversations, they received yearly bereavement training which supported them in developing their skills in breaking bad news.

The service had a designated bereavement suite which was accessible via a separate entrance. Parents were given free parking and a free burial service was offered by a nationally recognised cooperative brand which parents were signposted to.

The service understood the emotional impact of a bereavement and offered women keepsake boxes and the opportunity to place plaques of their babies' name on a memorial tree. Staff told us women can have as much time as they need in the bereavement suite. The suite provided bereaved parents with a calm and peaceful environment, situated away from the main maternity wards where they can create memories and spend time with their baby. Facilities included home comforts such as a double bed, kitchenette, ensuite shower and toilet, a sofa, and a memory book where parents can leave a hand-written note to their baby if they wanted to. Parents were supported to spend as much time as they needed with their baby.

Staff involved specialist midwives where additional support was required. For example, there was a lead bereavement midwife who was available during the women's admission and after discharge. Staff were friendly, helpful and responded sympathetically to queries or concerns women had in a timely and appropriate way. Women who had traumatic deliveries received a home visit to discuss their birth and a postnatal review.

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.

Staff made sure women and those close to them understood their care and treatment. Staff took time to explain women's care and treatment before they consented to treatment.

Staff spoke with women and families in a way they could understand, using communication aids where necessary. The service offered information leaflets in different languages. Staff had access to telephone translation and interpreting services. Staff told us they use picture flashcards to support communication when required. A flashcard is a non-verbal communication tool with images such as a plate of food to represent hunger. We saw staff communicating with patients with kindness.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We spoke with women who told us they felt comfortable to give feedback or raise concerns to staff. Women could provide feedback on their care through compliments, complaints and via the services "6 week After Care" call. Feedback received through the "Your Voice Is Heard" 6 week after care call was overwhelmingly positive. For example, 92% of women contacted were happy with the care they received and would return to the service.

Maternity

Staff supported women to make advanced and informed decisions about their care. The service aimed to facilitate women's individual birthing requests such as hypnobirthing or a water birth. We saw women's records showed completion of advanced care plans and we were told they were completed with women during antenatal appointments. The service also involved specialist midwives to enable them to make informed decisions about their care and treatment.

Women gave positive feedback about the service. Most of the feedback about the service was positive. However, one woman informed us her breastmilk had to be thrown away due to incorrect storage and she found this frustrating. Another woman told us the chairs were uncomfortable and there were no facilities for partners to stay. The trust scored 2.6 out of 10 for the subject "Partner who was involved in care being able to stay with them as much as they wanted.", in the CQC Maternity survey 2022 which was published 11 January 2023.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the needs of the local population. The labour ward, midwifery led unit and antenatal and postnatal ward were open 24 hours a day, seven days a week. The service provided a patient triage telephone line 24 hours, seven days a week for patients to speak with a trained midwife about any concerns they may have.

The community midwives offered a regular schedule of clinics for women who were postnatal and antenatal. For example, diabetic clinics and newborn hearing screening. All women were given the opportunity during these clinic appointments to ask questions and they were sent away from the clinic with their date and type of next appointment agreed. Women who had a homebirth had their first postnatal visit at home. They then attended a clinic appointment on day five and thereafter.

Staff could access emergency mental health support 24 hours a day, seven days a week for women with mental health problems and learning disabilities. The service had systems and specialist staff to help care for women in need of additional support or specialist intervention. For example, they had mental health midwives and specialist bereavement midwives. Staff completed maternity support forms to alert all staff about any specialist support women required; this information was shared with different teams.

The service was patient centred and adapted to the needs of the women. For example, if women had a learning disability, we were told they were more flexible to visiting arrangements and gave them a separate room for privacy. They also allowed partners and carers to stay comfortably if these adjustments would support the mother. Staff worked collaboratively with other teams to support women's care. For example, they would liaise with their social care worker.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services.

Maternity

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff understood how to apply and meet information standards to support patients' care and treatment. The service had access to information in large print, easy read and braille format.

The service had information leaflets available in languages spoken by women and the local community. On request, the service offered patient information leaflets which were translated to the patient's first language. The service had access to translation services and were focused on making the service accessible for all. For example, they had produced a discharge information video in six different languages commonly spoken by the local community.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpretation services to support communication.

The maternity department was clearly signposted and easy to find. It had a designated car park. There was plenty of seating in the waiting area for triage. The service was accessible for all and was located on the ground floor. There was an accessible disabled toilet with a red emergency pull cord which women and their families could easily reach.

The service had a bereavement suite, which was accessed by a separate private entrance. It had a dedicated parking space for partners and relatives to use. The lead bereavement midwife was available for support during the women's stay and following discharge through face-to-face discussions or telephone calls.

The service monitored the reason for re-admission for newborn babies. They monitored whether the baby could be supported in transitional care services and what provisions they would need to support transitional care. This was in line with national recommendations in the Avoiding Term Admissions into Neonatal units program.

Access and flow

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

The service held daily situation report meetings to discuss the access and flow of the maternity department. This was held with teams from both acute hospital sites and the community team. This helped them to determine where flow issues might be and identify solutions. The service had a "Maternity Escalation Policy including Closure of the Maternity Unit" policy to support decision making.

Managers monitored appointment numbers. The service monitored the number of bookings, antenatal appointments and antenatal day care appointments. This was to activity map the predicted number of deliveries to ensure access and flow was efficient as possible.

The service also monitored the number of postnatal appointments, postnatal day care and the number of babies born.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The service monitored the number of calls and attendances within the triage department. The service monitored when there had been delays against agreed timeframes for triage and audited the reason for the delay. The most frequent reason for a midwife and doctor triage time breach was because they were "busy elsewhere". The service reported incidents for each of these breaches to improve and learn.

Maternity

The service monitored the number of diverts between the William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital. In December 2022 there had been four internal diverts from the William Harvey Hospital due to the level of activity, with the number of women requiring one-to-one care outweighing the number of staff available.

Managers monitored patient moves between wards/services were kept to a minimum. The service moved women only when there was a clear medical reason or in their best interest. Managers monitored transfers and followed national standards. The service monitored transfer rates from homebirths and the midwifery-led unit to the labour ward. Women were only moved to the labour ward from their preferred place of birth when there was a clear medical reason to do so.

The service monitored readmission rates. The service had a 3.8% maternal readmission rate in December 2022 and a 10.6% neonatal readmission rate in December 2022. These figures were stable. The service had low intensive care unit admission rates and monitored these.

Managers and staff worked to make sure women did not stay longer than they needed to. Managers and staff started planning each woman's discharge as early as possible. The service had a discharge clerk to assist with timely discharge of women. They created a postnatal discharge pack which was individualised for each woman. This included referrals for additional services such as physiotherapy and community midwife appointments.

Staff supported women and babies when they were referred or transferred between services. Transitional women and babies were kept together on the maternity unit. The maternity team and special care baby unit (SCBU) team worked well to support the mother and baby. For example, the mother and baby would go to the SCBU for antibiotics, or SCBU staff would come to the maternity department regularly to monitor and review babies receiving phototherapy. Phototherapy is a treatment with a special type of light (not sunlight). It is sometimes used to treat babies with newborn jaundice, because jaundice is a condition that affects the function of the liver and can lead to long term disability.

Learning from complaints and concerns

It was easy for people to give feedback. However, it was not always obvious how women could 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.

The service did not clearly display information about how to raise a concern in patient areas. The service had information for patients on their website about how to make a complaint. However, the service clearly displayed patient feedback and advertised the “We Care” feedback campaign.

Staff understood the policy on complaints and knew how to handle them. Complaints received from the Patient Advice and Liaison Service (PALS) for the hospital were sent to the governance team and then on to the head of midwifery, matron, labour ward lead and consultant obstetrician. This team then reviewed the complaint and set a deadline to respond. Staff reported a good relationship with the PALS team.

Managers investigated complaints and identified themes. Complaints were recorded in the maternity dashboard; this included a theme and trend analysis. For example, the service had identified there were two recent complaints around communication issues. The service had begun investigations to look into these complaints and determine if any changes could be made. Complaints were also discussed during the women’s health clinical governance meeting**.** The service took complaints to a complaint steering group, which was held monthly.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. The service met with women to discuss the complaint and outcome of the investigation into their

complaint. For example, staff said they recently met with a woman who received a 3rd degree tear. They discussed the birth and decisions made during the birth with the woman. The community midwives told us a frequent complaint from women was around the lack of continuity of carer. The trust were working towards implementation of the continuity of carer plan, once the service had sufficient staffing.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service shared complaints feedback in team meetings verbally and written in the message of the week. Complaints were discussed at band 7 team meetings.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always understand and manage the priorities and issues the service faced. Staff did not know who the director of midwifery was and felt they were not always visible on the wards.

At hospital level, the service had substantive individuals in post. There was an experienced team of matrons reportable to the head of midwifery. There were two heads of midwifery, one based at each acute hospital. At ward level, the service had four skilled ward leaders, each covering a specific area of maternity. For example, one for triage and antenatal, one for the midwifery led unit, one for postnatal ward and one for the labour ward.

The care group for the service had a triumvirate structure which included: a director of midwifery, clinical director of women's health and an operations director. However, all of these positions were currently interim roles. There was also a current vacancy for the deputy director of midwifery role. This was a concern in light of the ongoing improvement journey the service was on. The triumvirate had regular meetings to discuss activity, finances and the maternity improvement plan.

Leaders had not understood all the issues the service faced in terms of safety and quality. For example, they had risk assessed their current situation with resuscitaires and felt it was better to take a newborn baby by hand away from its mother, up a corridor to a resuscitaire than to use a bedside resuscitaire as it presented a trip hazard. This meant a delay in emergency treatment. Despite this, leaders had identified some actions that were needed to address some of the concerns about the service. For example, there was an estates plan but this required sign off at executive level and had no dates for work completion.

Generally, leaders were visible and approachable. The midwifery service had a matron and staff were complimentary about this individual and felt they were visible and approachable if they had any concerns. However, staff did not know who the director of midwifery was and felt they were not always visible on the wards.

The head of midwifery and community was based at the hospital three days a week and based with the community midwifery team the rest of the time. Staff were positive about this individual and felt they were approachable. The head of midwifery and community reported having access to the trust board and felt well supported by them.

Maternity

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. However, staff were not aware of the strategy and how to apply it.

There was a vision, with quality and sustainability as the top priorities. The vision was "To be known as one of the top providers of maternity care and the provider of choice for women." And "To provide safe, women focused and sustainable maternity services with and for the women of East Kent."

Values had also been developed, which were: "Women and their families feel cared for", "Women feel safe", "Trust and respect sit at the heart of everything we do" and "We make a difference". These were aligned to the trust's values.

There was a strategy for achieving the priorities and delivering good quality sustainable care. The service had a strategy for "Excellence in Maternity Care". There were five objectives underpinning this strategy which were aligned to the trust's overall priorities:

1. Women and families,
2. Quality and safety,
3. Our people,
4. Our future,
5. Our sustainability.

Leaders said the strategy had been developed with relevant stakeholders such as women and their families and staff. However, most of the staff we spoke with did not understand what the vision and strategy for the maternity department was.

The service had been part of an independent investigation into its maternity and neonatal services (The Kirkup Report). The service had a change strategy following this investigation report, which was being delivered through five "Pillars of Change". The pillars of change included:

1. Reducing harm and safe service delivery,
2. Care and compassion,
3. Engagement, listening and leadership,
4. Organisational governance development,
5. Patient, family and community voices.

Staff did not have an understanding of this change strategy and what their role was in achieving it. We observed a lack of display notice boards or information for women in the service following publication of this report. The service had "Who can I talk to?" cards to direct women if they had questions or concerns about the independent investigation. However, these were not obvious in their placement in the ward areas.

Maternity

Culture

The service generally had an open culture where patients, their families and most staff could raise concerns without fear. However, not all staff were aware of who the Freedom to Speak up Guardian was and some staff felt they would be punished for speaking up. Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work and did not provide equal opportunities for career development.

The trust and maternity service was addressing identified cultural issues. The recent independent investigation into maternity and neonatal services at the trust had identified deep-seated and longstanding problems of organisational culture in the trust's maternity units. The report stated "The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively.". The report identified eight clear separate opportunities when that could and should have happened. Senior managers told us they were working to improve this culture and sought support from external stakeholders including NHS England to help them to address this. The trust were developing a culture and leadership program as a strategy to ensure the trust had a culture that deliver high quality, inclusive, continuously improving and compassionate care.

Staff generally felt supported, respected and valued. All staff we met during our inspection were welcoming, friendly and helpful. They felt proud with the peer support they gave each other and having worked together to provide the best service they could to women and babies in their care. Staff told us they felt positive about working for the service and they felt supported. The community midwifery team told us they felt the culture and attitudes towards them had improved.

The service's culture centred on the needs and experience of people who used the service. There were mechanisms to gain patient feedback and improve services as a result; such as "Your Voice is Heard" and the complaints and incident investigation process.

Leaders understood the importance of staff being able to raise concerns without fear of retribution and operated an 'open door' policy. Most staff told us they felt able to raise concerns without fear. However, there were a few individuals who felt they could not speak up and talked about a perception of punishment by removing their access to bank shifts when they did raise concerns. We raised these concerns with the executive team following the inspection.

The service had a speak out service known as "Shout Out Safety" (SOS) on the trust intranet. This allowed staff to report concerns using their name or anonymously if they wished. If they reported anonymously, concerns were sent to the trust governance team. If they reported using their name, the concerns went to the Freedom to Speak up Guardian. This system encouraged staff to report unsafe patient care, unsafe working conditions, inadequate induction or training for staff, lack of responses to patient safety issues, suspicion of fraud and bullying. However, not all staff were aware of this system. Furthermore, not all staff were aware of who the Freedom to Speak up Guardian was.

There was a strong emphasis on the safety and wellbeing of staff. Following publication of the independent investigation into the maternity services and neonatal care, the service had repurposed one of its rooms into a wellbeing room. This had an electronic massage chair, which we were told was a Christmas present for the staff and was a safe and homely environment for staff to take time to focus on their wellbeing. The service also had a clinical psychologist who held drop-in sessions in the wellbeing room two times a week.

Maternity

The service had an 87% compliance rate for yearly appraisals for staff. Staff had developmental support from clinical skills facilitators and practice development midwives. The service offered funding for masters degrees for staff and newborn and infant physical examination (NIPE) training courses. Ward leaders told us they wished there was more to offer staff in terms of development, but staff felt well supported and that they could develop.

The service actively thought about succession planning and talent management. For example, the trust had facilitated one-to-one coaching for 26 members of the maternity staff. This had enabled 14 members of staff to progress in their career having been successful in achieving interim and permanent posts in the maternity service.

Equality and diversity was not always promoted within the service. The service participated in the trust Workforce Race Equality Standard (WRES) data. The trust did not perform well in the 2021 WRES report. For example, the trust performed worse than the national average for:

- ethnic minority staff receiving harassment, bullying or abuse from patients, relatives or the public in last 12 months;
- ethnic minority staff receiving harassment, bullying or abuse from staff in last 12 months and
- ethnic minority staff receiving discrimination from a manager/team leader or other colleagues in last 12 months.

We reviewed the trust action plan against the 2021 WRES report. There were clear actions to address where there were downfalls. For example, “empowering staff to share their lived experience stories to raise awareness and promote meaningful culture change”, “holding cultural events to educate the workforce and celebrate diversity” and “Continue to embed Just Culture Programme to promote and embed meaningful change”.

We reviewed the trust action plan against the 2021 Workforce Disability Equality Standards report. Actions included: “Empowering staff to share their lived experience stories to raise awareness and promote meaningful culture change, including at Executive Board level.” and “Developing the Disability Staff Network to provide a safe and supportive space for staff who have disabilities.”.

However, the service had held visions and values workshops, equality and diversity events and there was a trust wide “Respect and Inclusion Promise”.

There were cooperative, supportive and appreciative relationships among staff. Staff worked in a collaborative and cooperative team to ensure the patient experience was the best it could be.

All staff had a dedicated professional midwifery advocate (PMA) who they could go to for support. Staff said this worked well and they felt well supported. They also used a ‘PMA of the day’ system so all staff could approach that individual for support. Staff who were PMA’s had lanyards to identify them, so staff knew who to approach for support.

Governance

Leaders followed governance processes, the service was on a governance improvement journey. Staff at all levels were clear about their roles and accountabilities. However, not all staff felt there was regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

The service had clear structures, processes and systems of accountability to support the delivery of the strategy and good quality services. The service had an overarching policy named "Maternity Services Quality and Safety Framework (including Risk Management Strategy)". This outlined the governance processes for the whole service including, patient safety, patient experience and clinical effectiveness. This included an organogram of the governance meetings. This policy had been approved in August 2022 and therefore was still in the process of implementation and embedding.

The service provided assurance to the trust board through their Maternity and Neonatal Assurance Group (MNAG) and reported directly to the trust board through the quality and safety committee. MNAG had the trust chief nurse as the chair, which provided executive oversight. It was also attended by the non-executive director who acted as the safety champion for maternity.

The service had groups for discussion and action planning which included the patient safety group, audit group and guidelines group. These meetings escalated and fed into the women's health governance committee, which had overall authority on decision making.

We reviewed a variety of meeting minutes from differing governance meetings and found the levels of governance and management were starting to function effectively and interact with each other appropriately.

The service was on an improvement journey in terms of governance and had recently created an improved interim governance structure of the staff required to implement the governance strategy, with new roles to be hired into. There were seven specialist governance midwife level roles including compliance and assurance, audit research, patient safety and lead investigation. These midwives directly reported to the interim governance matron who reported to an interim deputy head of governance for maternity. This staffing structure had some vacancies and was still in the process of embedding. We were told the service was starting from a low level of governance, but it was hoped the team would help to drive improvement in governance processes.

The governance team were being supported by a national maternity advisor from NHS England and NHS Improvement and an individual on a consultancy basis. Following a scoping exercise in December 2021 to identify areas for improvement within maternity governance processes, an action plan was developed. This had 120 actions and at the time of our inspection, 57% of these actions had been completed. Progress against the governance action plan was managed and monitored through the maternity improvement plan.

The service had a maternity improvement plan. This held the trust's cross site gap analysis on the maternity services provided to national publications and maternity incentive schemes. The improvement plan had an action tracker to monitor their actions. The trust had benchmarked themselves against 1222 actions that the trust was responsible for, each action had a named owner. We saw the trust had rated themselves as assured on 609 actions, partially assured on 239 actions and not assured on 172 actions. The remaining 202 actions had not been assessed. Actions that the trust rated themselves as not assured on included incidents and governance.

Staff at all levels were clear about their roles and understood what they were accountable for. However, staff were not able to tell us about recent learning from incidents in the service and some staff felt there was a lack of discussion around governance with them.

An independent review into maternity and neonatal services at the trust that looked at the care and treatment of women, babies and their families in the care of the trust between 2009 and 2020, was published in October 2022. The report identified "those who were responsible for the services too often provided clinical care that was suboptimal and

led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.". The trust has issued a public statement and apology on the findings of the report. From review of the board meeting papers dated February 2023, the trust has stated they are committed to addressing the four areas for action that were identified in the independent review, these are:

1. Monitoring safe performance,
2. Standards of clinical behaviour,
3. Flawed team working,
4. Recommendation specifically for the trust to embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring the safety of the environment and equipment at the maternity department. This included elements of infection prevention and control.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified some actions to reduce their impact. However, risk and performance issues were not always well managed or communicated to staff. Some staff felt there was a lack of discussion around risks. The maternity dashboard was not displayed in clinical areas, which meant staff and the public were not informed of the outcomes and risks of the maternity service.

There were some assurance systems in place. Risk and performance was discussed at numerous meetings including MNAG, women's health clinical governance committee and the patient safety group meetings. For example, during MNAG maternity risks on the trust corporate risk register were discussed.

The service had a programme of clinical and internal audit to monitor quality. However, risk and performance issues were not always communicated to staff and some staff felt there was a lack of discussion around risks with them.

The service had arrangements for identifying, recording and managing risks. The service had a risk register which included mitigating and risk reduction actions. There was an alignment between the recorded risks and what staff said was 'on their worry list'. For example, their top risks were staffing levels and implementing effective governance processes. However, there were serious risks we found during the inspection that were either not on the risk register or had inadequate control measures in place.

There were processes to manage current and future performance. The service had a maternity dashboard in the form of a report, this was regularly reviewed at MNAG. The maternity dashboard included a number of metrics the service was using to monitor their performance and these included serious incidents and maternal and neonatal readmission. Metrics were RAG rated to enable staff to identify areas that were better or worse than expected. However, the dashboard was not displayed in clinical areas and meant staff and the public were not informed of the outcomes and risks of the maternity service.

Community midwives followed a lone working policy to reduce their safety risk. However, staff told us they were concerned attending homebirths alone at night. They told us they had suggested to managers that two midwives meet and go to the birth together, however they had not received a reply to this suggestion.

Maternity

Information Management

The service collected reliable data and analysed it. However, there was not sufficient coverage of both quality and sustainability. Staff could find the data they needed to understand performance. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a holistic understanding of performance. This information brought together women's views of the service with information the service had on care quality and clinical outcomes. The service used this information as part of their maternity dashboard and held regular discussions about performance.

However, there was not sufficient coverage of both quality and sustainability. The service was currently on an improvement journey and staff described they were not in a place to think about sustainability. We were told the trust had to submit a sustainability plan to NHS England and NHS Improvement to come off their Maternity Safety Support Programme.

There were clear service performance measures reported and monitored through the maternity dashboard. Results from clinical audits and safety tools fed into this dashboard.

The service had effective arrangements to ensure data or notifications were submitted to external bodies as required. For example, the service reported incidents to Healthcare Safety Investigation Branch (HSIB) when an incident met their criteria. Furthermore, the service reported data to Mothers and Babies: Reducing Risk (MBRRACE) national audit.

The information systems were integrated and secure. The service had arrangements to ensure confidentiality of identifiable data, records and data management systems, in line with data security standards. Authorised staff had access to electronic patient records, which was restricted to individuals by their own login and passwords. Staff completed information governance training and 87% of staff were up-to-date with their training.

Engagement

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

Women and those close to them were actively engaged with to gather views and experiences. These were acted on to shape and improve the service and culture. The service collected women's views through complaints, compliments, NHS Friends and Family Test (FFT) and through their "Your voice is heard" campaign.

The service undertook the FFT with inpatients. All inpatients were asked how likely they were to recommend the ward to friends and family. In December 2022, 90% of patients responded positively to this question. However, the service had a 14% response rate.

As part of the "Your voice is heard" campaign the service offered all women and their families on discharge a "6 week After Care" call to ask what went well during their care and what could be improved. In December 2022, the service had a 74% response rate to these calls with 322 women giving their feedback on a call. The calls found that 92% of women were happy to return to the service.

The service RAG rated the results. Positive antenatal care and positive intrapartum care were rated as green. However, a positive postnatal experience was rated as red, with 83% of women agreeing. The service had acknowledged the decline in positive feedback for postnatal care. They recognised the need for a pathway review for postnatal care in the hospital and community.

Maternity

Following the “6 week After Care” calls, the service collated themes and took action to address them. For example, there was feedback that water jugs were not always topped up and there was no access to water coolers. In response to this, the service had taken action to ensure water is offered at least every four hours during ward rounds and they had agreed for water coolers to be installed on both sites.

The service had regular opportunities to meet with staff and engage with them. We were told the service had a formal team meeting every month. Their purpose was to update staff on operations and share learning. However, staff were not always aware of recent learning.

The service collected results from the staff survey, the last survey was completed in October 2021. There was a 13% response rate to the survey, this was 17 individuals with poor engagement scores. The service told us they had completed a staff survey in 2022 however, these results had not been released during the time of our inspection.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of women. The service held meetings with the local maternity voice partnership (MVP) to improve the services for women. Staff told us they had good relationships with the MVP and met with them regularly. We reviewed agendas and meeting minutes between the MVP and the service, and it appeared there was a collaborative exchange of information for the benefit of women and babies.

Learning, continuous improvement and innovation

Leaders encouraged continuous learning, improvement and innovation, but not all staff felt they had the time or the information to learn from feedback.

The service had a maternity improvement plan. The improvement plan had an action tracker to monitor their progress against the actions.

The service had access to a trust-wide improvement strategic framework called “We Care”. This outlined what the trust breakthrough objectives were and how this fed into improvement workstreams. It was not obvious what quality improvement tools the service used to drive such improvement.

The service had a structured audit process and part of this process was to identify actions for improvement. Leaders completed internal and external reviews, including incidents and complaints.

Staff continuously sought feedback from patients to improve services. The service had recently reviewed it’s bereavement pathways. The service met with 27 bereaved women and their families who had used their services to discuss the bereavement pathway and how it could be improved. The service engaged with this group during the recruitment process for the bereavement team. For example, they gave feedback on the job descriptions.

The service had improved their triage process. The triage service had implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS), we observed that this process was working well in the department.

Outstanding practice

We found the following outstanding practice:

Maternity

- The service had implemented “6 week After Care” calls following women’s discharge, to ask what went well during their care and what could be improved. The service had a good response rate to these calls.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure care and treatment is provided in a safe way in relation to resuscitaires in the labour suites. The service must do everything that is reasonably possible to mitigate this risk. (Regulation 12(2)(b)).
- The service must ensure the emergency equipment for providing care or treatment is safe for use. Safety checks must be completed to ensure equipment is safe and fit for purpose. (Regulation 12(2)(e)).
- The service must improve medicines management across all its maternity services. This is to ensure prescription stationery are monitored and accounted for, medicines are stored securely, women have their medicines in a timely way, staff have prompt access to medicines (including medical gases when required), staff have adequate space to safely manage medicines and expired medicines are removed from stock. (Regulation 12(2)(g)).
- The service must ensure all staff are up-to-date with safeguarding adults and children at the appropriate level. (Regulation 13(2)).
- The trust must ensure the environment and facilities are improved to meet the needs of women and babies. (Regulation 15(1)(c)).
- The service must ensure continued compliance with fire safety in the maternity unit. (Regulation 15).
- The service must ensure domestic, clinical, hazardous and sharp waste materials must be managed in line with current legislation and guidance, including having an up-to-date waste management policy. (Regulation 15(1)(a)).
- The service must ensure guidelines are up-to-date so staff follow accurate information to deliver evidence-based care and treatment. Compliance against guidelines must be monitored through audits in a timely manner. (Regulation 17(2)(a)).
- The service must ensure they continue with progression against their governance action plan and maternity improvement plan. (Regulation 17).
- The service must ensure all staff are up-to-date with mandatory, statutory and maternity specific training. (Regulation 18(2)(a)).

Action the service SHOULD take to improve:

- The service should consider auditing completion of consent records.
- The service should consider displaying the maternity dashboard data in clinical areas for women and families and staff to view.
- The service should consider a separate and private environment for women to feed their babies.

Maternity

- The service should ensure they have considered the baby abduction risk and explored ways to improve security in the department. (Regulation 12).
- The service should ensure all equipment has been cleaned regularly. (Regulation 12).
- The service should ensure sufficient pharmacy support to the maternity unit. (Regulation 12).
- The service should ensure milk is stored securely. (Regulation 12).
- The service should ensure information and guidance about how to complain is available and accessible to everyone who uses the service. (Regulation 16).
- The service should ensure all staff understand the services vision and strategy. (Regulation 17).
- The service should ensure all records are stored securely. (Regulation 17).
- The service should ensure learning from performance, risk, governance and incidents is fed back to staff and staff are given time to read and understand the information. (Regulation 17).
- The service should ensure they identify ways to improve staff engagement and participation in staff surveys. (Regulation 17).

Our inspection team

During the inspection, the inspection team:

- visited the service and looked at the environment
- spoke with the triumvirate for the service
- spoke with key leaders such as the head of midwifery, matron and ward leaders
- spoke with 25 members of staff
- spoke with four patients and reviewed patient feedback
- reviewed five patient records
- attended meetings including the safety huddle, rapid review group and the maternity and neonatal assurance group
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

The team that inspected the service comprised a CQC inspection manager, CQC lead inspector, three other CQC inspectors, a CQC medicines inspector and two specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.