East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Inspection report

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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?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at William Harvey Hospital

Inadequate 

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

- The service did not always control infection risk well. Staff did not always use control measures to protect women, and other pregnant people, themselves and others from infection. Equipment and the premises were not always visibly clean. The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always check emergency equipment in line with policy to ensure this was ready, safe and fit for purpose.
- The labour suites were not equipped with resuscitaires which impacted on timely access for babies requiring emergency care. Staff did not always ensure a second opinion was sought; a process called the 'fresh eyes'.
- Services were not effectively planned to meet the needs of women. The midwife led unit was not available to women and birthing women did not have access to the birthing pool.
- The service did not always have enough staff to care for women and babies and keep them safe. Assessments and records of care were inconsistent and posed risks of important information not being recorded and acted upon.
- There was a lack of learning from incidents. The incidents investigation backlog impacted on risk management. Action plans could not always be translated to learning as they were not embedded, therefore there was a risk of recurrence of incidents. There was a backlog of incidents which had not been reviewed, investigated and action plans had not been developed to mitigate risks of recurrence.
- Care and treatment did not always reflect current evidence-based guidance, standards, best practice and technologies. 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.
- The service was not planned or providing care in a way that met the needs of all local people and the communities it served. Services were not always accessible to women. There were delays to discharges and these were not monitored. The triage and day care facilities were poor, and women were cared for in a chaotic environment. Women were not always cared for in appropriate environments due to challenges in managing flow across the maternity unit.
- 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 breastfeeding support team provided a good service. They were responsive and supportive, and available seven days a week, providing services in the unit and at home.
- Staff had training in safeguarding women and babies and understood how to protect women from abuse and took appropriate actions.

Our findings

- The bereavement service supported women and their families appropriately and sensitively.
- Staff were responsive and worked hard, with limited resources, to meet the needs of women and their families.
- Staff assessed and provided good support for women with mental health needs, including timely referrals to mental health teams.
- Staff worked well together in their immediate teams for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Key services were available seven days a week.
- Staff treated women with compassion and kindness.
- The service took account of women's needs and made it easy for people to give feedback. The service engaged well with women receiving care as inpatients and in the community and used feedback to improve services.

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 William Harvey Hospital (WHH) is one of 5 hospitals that form part of East Kent University Hospitals NHS Foundation Trust. The maternity service at the WHH hospital delivers approximately 3,500 babies each year. East Kent University Hospitals NHS Foundation Trust has another acute hospital with inpatient maternity services called the Queen Elizabeth the Queen Mother Hospital. The trust also provides community maternity services from Kent and Canterbury Hospital and Buckland Hospital.

The maternity service at the WHH included a day care, triage and antenatal clinic, Singleton midwifery led unit, Folkstone ward which is an antenatal and postnatal ward and the labour suite.

Singleton midwife led unit had 8 beds, 2 of which have birthing pools, however, this had been closed for the past 18 months and therefore this service was not available to women.

The labour suite had 8 labour beds, 3 induction of labour rooms and a room with a birthing pool.

Folkestone ward had 28 beds. This consisted of 4 bays each with 4 beds, and 8 side rooms for antenatal or postnatal care and a 6 bedded transitional care bay which was not operational. This was used as postnatal area at the time of the inspection.

The day care unit had 2 chairs and a sideroom.

Outpatient services consisted of antenatal clinics, the day assessment unit, ultrasound and fetal medicine and other specialist clinics such as diabetes, twins/multiple births and perinatal mental health.

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 WHH hospital on 10 and 11 January 2023. We also visited the community midwifery services at Kent and Canterbury Hospital and Buckland Hospital.

Is the service safe?

Inadequate

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

Mandatory Training

The service provided mandatory training in key skills to all staff, however the trust's training targets were not always achieved.

Staff received and mainly kept up-to-date with their mandatory training.

Maternity

The trust had set a target of 85% for completion of mandatory training. Data provided by the trust, dated December 2022, showed maternity services were meeting or were close to meeting the trust's target. This included newborn life support, fetal heart monitoring, infection prevention and control, hospital life support and Practical Obstetric Multi-Professional Training (PROMPT).

All staff groups had achieved 91.6% in PROMPT training. The service acknowledged they had challenges with delivery of PROMPT training due to availability of multidisciplinary staff due to staffing pressures. Midwives achieved 89% in fetal monitoring, and doctors 89% in neonatal life support.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed additional training such as cardiotocograph (CTG) and neonatal life support. We saw for December 2022, compliance with fetal monitoring training was 91%.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Data showed as of December 2022, 92% of staff had completed diversity awareness training. However, only 78% of staff had completed dementia training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Medical staff had been allocated a week's protected time for mandatory training, although compliance was below the trust's target.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse.

Staff received training in safeguarding adults, levels 1, 2 and 3. Staff were 100% compliant with level 1 safeguarding adults; however, level 2 safeguarding adult compliance was 82% and 80% of staff were compliant with level 3 safeguarding adults, which was below the trust target of 85%. The service told us it was predominantly medical staff who were non-compliant with safeguarding training. This was also identified at the last inspection and had not improved.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Assessments were completed at the antenatal stage which included risks of alcohol, drugs and domestic abuse. Staff worked with other agencies and followed their internal processes to protect women and their babies.

The midwifery service took a multidisciplinary approach to safeguarding and they described how they liaised with the trust's safeguarding team, other departments, community services and the local authority's safeguarding team. Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, they reported the safeguarding team were not always responsive or supportive and had rarely attended the unit.

The trust followed the mandatory requirement to provide a report to the Department of Health on the number of women who have had female genital mutilation (FGM) or who have a family history of FGM.

The staff were clear where FGM was identified, it was mandatory to record this in the women's health record. The service followed their process to facilitate the FGM reporting requirement and clear guidelines were available to staff in recognising and supporting women who may have experienced FGM. This included children of women who may be at risk of FGM.

Staff followed safe procedures for children visiting the ward. Staff followed the baby abduction policy and procedures. All babies were tagged in line with trust policy as soon as possible following birth. Staff followed the baby abduction policy and undertook baby abduction drills.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use control measures to protect women, themselves and others from infection. Equipment and the premises were not always visibly clean.

Cleaning records were not up-to-date to demonstrate that all areas were cleaned regularly. On Folkestone ward staff did not always complete daily cleaning, we found equipment that was not clean and was dusty. Cleaning records had gaps and were not recorded as completed on 3 dates in January 2023, 9 dates in December 2022, and 11 dates in November 2022.

Staff did not follow procedures for ensuring blood spillages and body fluids were managed in line with safe infection control policy and guidance. We saw poor infection control practices which included unsafe management of body fluids, such as urine left in a receptacle in a toilet for a prolonged period of time, and bloodstains on toilets.

Staff cleaned equipment after patient contact, they did not label equipment to show when it was last cleaned. In the labour ward, staff cleaned equipment after patient contact, however, we saw not all staff labelled equipment following cleaning to show when it was last cleaned and ready for use. This meant labelling of equipment following cleaning was not a consistent practice in all the areas that we visited.

Care and treatment was not always delivered safely to protect women and babies from infection control risks. We saw staff did not wear personal protective equipment (PPE) correctly. In addition, we saw that staff did not always clean their hands in between patients in line with trust policy and national guidance. We saw non-compliance with hand hygiene, after contact/clinical procedures with patients. In Triage and Day Care, we routinely saw staff did not always clean their hands, and use PPE, such as gloves and aprons, when delivering care to women.

Personal protective equipment was readily available for staff in all clinical areas to ensure their safety when performing procedures. However, this was not always used in line with the service procedures.

The service completed regular audits on hand hygiene and PPE usage. The audit demonstrated compliance was good, however we saw staff did not wear PPE correctly.

Staff in the labour wards wore scrubs and were bare below the elbow in clinical areas, which was in line with the trust policy to reduce the spread of infection. Some staff in other clinical areas did not always comply with the trust uniform policy, including hair was not tied back and nail varnish was worn. For example, in triage, we saw a midwife who was seeing patients and wore nail varnish.

Infection control procedures included side rooms for isolating patients if patients had or were suspected of having an infectious condition. Staff were provided with PPE when accessing the isolation areas, to minimise the spread of infection.

Maternity

Procedures had been developed to assess patients and they were routinely screened for MRSA, as part of their pre-operative process. Staff followed the trust's procedures, including routine testing of susceptible patients in line with best practice guidelines.

Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring infection control practices at the maternity department.

Environment and equipment

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

The design and the environment did not effectively meet the needs of women and their family and did not follow national guidance. The hospital was built in 1977 and some areas were no longer fit for purpose. The labour ward and delivery suite, maternity day care and triage areas were small and cramped, and the main treatment area was not private. This was identified at our last inspection and there had been no improvement.

The trust had recognised the environment needed significant investment and had submitted a bid for capital to make improvements. The trust had a maternity estates improvement strategy. This was under development to improve the current maternity services estates at William Harvey Hospital. Phase 1 plans had been agreed to improve several areas, which were outlined to us in documents provided.

Staff did not carry out daily safety checks of specialist equipment. The maintenance and use of equipment did not always keep women and babies safe. Resuscitaires were not available in the labour suites, they were kept in a different area of the labour ward, along a corridor. This posed a high risk of delay in the emergency treatment for babies. A neonatal resuscitaire is a device which combines a warming therapy platform along with the components needed for clinical emergency and resuscitation. This meant in the event of an emergency, the baby was moved away from the mother, who would be unable to see or be with her baby during a potential life threatening and worrying time.

Staff told us there was no room to store neonatal resuscitation equipment in the labour rooms. The service had a risk register entry about the size of labour rooms not being able to facilitate resuscitaires. The risk register entry had recorded actions to mitigate the risk, "The equipment is placed in a safe environment to maintain privacy and dignity during the resuscitation procedure". This was not always the case as resuscitaires were located in the corridor and staff would take the baby from the labour room to the resuscitaire.

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

Equipment was not regularly serviced. We reviewed the equipment asset log and identified that a significant number were out of date for servicing. These included resuscitaires; LEDs for phototherapy; dopplers and fetal monitoring sonicaids. Information from the trust showed a resuscitaire was due to be serviced on 29 April 2022 and this had not been serviced at the time of our inspection. The lack of appropriate monitoring of equipment exposed babies and mothers to the risk of harm as equipment may not be fit for use for routine care and in case of an emergency.

During our review of information, we found an incident which occurred in July 2022, where a baby was born in an unexpectedly poor condition. The midwife-initiated resuscitation was ineffective due to appropriate equipment not being checked or available.

Maternity

Following our inspection, we asked the provider to take immediate action to ensure the safety of women and babies within the labour wards. This included neonatal resuscitation equipment not being available to use at the bedside. In response the trust has re-positioned key equipment within delivery rooms to allow space for a resuscitaire, and a central resuscitation room has been created to ensure additional access to neonatal resuscitation. Additional resuscitaires were being urgently purchased to make sure there was a neonatal resuscitaire in all labour rooms.

In triage there was emergency equipment in relation to resuscitation for baby in case of rapid delivery. The adult resus trolley was on the postnatal ward around the corner. There was an emergency delivery pack present too, which meant there could be delays in retrieving emergency equipment when needed. Staff told us of incidences where women had given birth in the triage area and labouring women were cared for in triage whilst waiting for beds in the labour ward.

Staff did not always carry out daily safety checks of specialist equipment. This was of concern in the postnatal ward where the daily checks on the resuscitaires had not been completed in line with practice guidelines. In December 2022, the resuscitaires were checked on 15 days out of 31. In January 2023, checks were carried out on 4 out of 9 days.

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.

The resuscitation equipment in the community maternity unit at Kent and Canterbury Hospital was not managed safely. Emergency resuscitation trolleys had algorithms to help staff in an emergency; these were dated 2015 and had not been updated in 2021 as planned. Evidence of emergency checks for a week in December 2022 and two weeks in November 2022 were missing, and there was no data for January 2023. The trust could not be assured equipment was safe for use and staff were providing care and treatment in line with current guidelines.

We requested data from the trust relating to emergency equipment safety checks for July 2022 to January 2023, this showed in the maternity wards the compliance ranged between 17% to 100%. For the community settings, safety checks for July to August 2022 ranged between 33% to 100%. There was no data available for the community team services from August 2022 to January 2023. The trust could not be assured equipment would be functioning correctly and staff were fully equipped in an emergency.

Women were not always supported with facilities to meet their individual needs. There was one birthing pool, however this was not available to labouring women. The trust said that due to the challenges around ventilation and the use of gas and air, the room could not be used for labour care or the induction of labour. The trust has told us that this essential safety work has been completed, and the room is back in use for women who are wanting to use a pool..

Emergency equipment was poorly maintained. The emergency call bell system in the community maternity unit at Kent and Canterbury Hospital was not working. The unit was used as a clinical venue for midwives and a satellite clinic for obstetrics. Criteria for attendance had been restricted to reduce the risk of obstetric emergencies.

There was no neonatal emergency equipment in the community maternity unit at Kent and Canterbury Hospital, the nearest one was at the William Harvey Hospital and staff relied on 999 as needed.

Kent and Canterbury Hospital was an old building with several estates issues, including several leaks. Feedback from staff was that requests for work to be done were submitted but not always responded to. We observed sinks which were not in use and needed to be removed, old bathrooms with mould which were not fit for use, but they had not been removed to make more efficient use of space. Managers said there were plans drawn up for a new unit near the outpatient department but no date or timeline for the work had been agreed.

Maternity

Staff disposed of clinical waste safely and in line with the trust policy. Clinical waste was stored in locked areas, and this was removed regularly from clinical areas. Sharps bins were available in treatment areas, the bins were shut when full to prevent overfilling. We saw labels on sharps bins which indicated the date it was constructed, by whom and on what date.

There was only one counselling room that was also used as the fetal medicine unit/office where women attended for scans. There was no indicator on the door to indicate when the room was occupied. Staff told us "If the door is shut, likely it's occupied". This meant staff could not always protect women's privacy and dignity during consultations and when having procedures.

Assessing and responding to patient risk

Staff had tools available to assess, manage, monitor and respond to the safety of women and babies, however these were not used consistently or effectively.

Staff used a nationally recognised tool to identify women at risk of deterioration; however, this was not used consistently in assessment in order to ensure appropriate escalation. The trust had identified the use of Maternity Emergency Obstetric Warning Score (MEOWS) was not always completed in a timely way. The service had completed an audit between August and December 2022 of MEOWS chart compliance which showed between 26% to 43% completion of applicable observations were recorded.

Staff used cardiotocography (CTG) to monitor the baby's heart rate, but processes were not consistently followed to systematically review, interpret and assess risk. Records of women showed that cardiotocography (CTG) monitoring was taking place, however the 'fresh eyes' process was not consistently followed in line with the trust policy and guidelines. Misinterpretation of CTG can be a common issue in practice but using a simple buddy system such as 'fresh eyes' can produce significant improvements and positively impact on the welfare of women and babies. We looked at 7 records and saw in 3 of them the 1 hourly 'fresh eyes' review was not consistently recorded.

Following the inspection, we requested further information on fresh eyes audits. Trust data for 25 to 31 January 2023 showed a low level of compliance with 'fresh eyes' processes. The audit result on 24 January 2023 demonstrated that none of the set criteria was being met, this included the use of a sticker, hourly fresh eyes care completed by two staff, and CTG signed by two staff. For the same period, there were 14 episodes where fresh eyes care was not done hourly by two staff, this was not in line with trust policy and recommended practice guidelines.

Staff were not completing the fresh eyes 'Fetal Monitoring Ongoing Assessment Tool' in line with the internal policy which required staff to ensure the CTG tracing was signed to include type of hypoxia.

We asked the trust to take immediate action in relation to appropriately monitoring mothers and babies. The trust told us they had developed a process to ensure regular oversight in the wards and data was added to the maternity dashboard to review compliance by the end of January 2023.

Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring the safety of women and babies using cardiotocography (CTG) monitoring and fresh ears/eyes at the maternity department is effective. This included intermittent auscultation (IA) and CTG audits.

Maternity

The fetal medicine service did not meet the needs of women. Midwives saw over 20 women per day. Midwives took responsibilities for plotting graphs following ultrasounds. Midwives were responsible for assessing fetal growth and escalating if abnormal readings were identified. Staff told us there was no mechanism for medical staff to review scans and this should not be a midwife function. Midwives also reviewed dopplers and discharged women if found within normal limits. There was no medical oversight.

There was a maternity triage service. The maternity triage service is the emergency access for women requiring maternity services with unexpected complications and concerns about fetal well-being. Triage documentation was not robust which did not always protect women. For example, important information, was not recorded, and requests for a doctor review were not always responded to promptly. Maternity staff had raised this as a serious concern with senior management at a meeting in December 2022. Concerns from staff included the triage area being inappropriately used for care, such as midwives looking after women in labour, and extended stays in triage due to bed capacity on labour suites and lack of staff.

Women who presented with pregnancy related problems or concerns were triaged over the phone and signposted to the best care pathway. The Birmingham Symptom-specific Obstetric Triage System (BSOTS) was still in development and was not fully integrated in women's assessments at triage at William Harvey Hospital. The BSOTS was developed to better assess and treat pregnant women who attend hospital with pregnancy related complications or concerns. Following the inspection, the trust told us they recognised that the BSOTS triage pathway was in the early stages of implementation at the William Harvey Hospital. Data showed there were gaps in documenting the red, amber and green (RAG) status for women which was 38% for November 2022 and 34% for December 2022. The trust plan was for this to be part of the monthly maternity dashboard report.

Women requiring information and support were poorly served. All enquiries to the service came through the triage phone, as the service did not have a pregnancy helpline. There were no records of all calls to the triage lines as only those which were 'clinically relevant' were captured. If women were asked to attend, a triage assessment call document was then completed. Staff told us there was lack of support and oversight from the band 7 midwife who remained in the labour ward and women did not receive support in a timely way.

The triage process was not managed effectively as staff saw all planned work and scan reviews, which should be seen in the day assessment unit. This impacted on the staff who should be seeing women presenting with problems in pregnancy and early labour.

The timeliness and effectiveness of processes in triage was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm. On the day of the inspection, there were concerns about care of women due to flow and lack of beds to admit, which meant women were not always cared for in an appropriate environment. For example, a woman on intravenous antibiotics had been in triage unit for over 9 hours. Another woman attended for an external cephalic version (ECV) procedure and had been waiting for 3 hours as there were no beds on the labour ward.

Following our inspection, we imposed conditions to ensure there is a system in place for assessing, managing and monitoring the safety of women and babies using triage services at the maternity department.

Community face to face visits for all mothers and babies discharged started again from November 2022 onwards. Women received a phone call except when specified that a visit was needed. Planned home visits now occurred on day 5, midwives were unsure whether home antenatal visits took place.

Maternity

During the inspection, we observed the use of the World Health Organisation (WHO) checklist for women attending obstetric theatre. We reviewed the WHO checklist audit for the period between October 2022 to January 2023, this was between 89% and 92% which was below the trust target of 100%.

There were processes to follow when women had deteriorated. Staff used the trust's escalation procedure and received support from the Critical Care Outreach Team (CCOT). The CCOT responded to emergency calls and liaised with the critical care consultant/anaesthetics and the pain team as required, they routinely saw critical care step down patients.

The trust had developed a specialist twins clinic which was consultant led. There remained a need for a lead specialist midwife and specialist sonographer for twins, these posts were planned to be recruited to.

Women had a named consultant for high-risk pregnancies or a named midwife for low-risk pregnancies. Staff had completed appropriate risk assessments for women during their antenatal attendance using a recognised tool.

Women were assessed for the risks of blood clots (VTE) and staff identified women most at risk. Interventions included prescribing the use of prophylaxis medicines to reduce the risk of VTE.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. Staff would develop a crisis plan for women with mental health needs.

Staff completed, or arranged psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. During the safety update, staff shared key information to keep women safe when handing over their care to others.

Shift changes and handovers included some necessary key information to keep women and babies safe with reference to their social, health and psychological wellbeing.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe and to provide care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and midwifery staff to keep women and babies safe. The staff shortage impacted on women in a variety of ways. For example, women were sent back to triage from the labour ward which was not an appropriate place for them due to staff shortages.

The last bi-annual midwifery staffing review was presented to board in December 2022. This showed that band 6 and 7 midwifery staff had the higher vacancy rates. There were higher Band 5 staff at +13.8. Feedback from staff included "feeling exhausted" and "sometimes with no breaks on shifts". Several staff had left, recruitment particularly for band 7 midwives was challenging and morale among staff was low.

The percentage of specialist midwives employed, including those in management positions had previously been reported as 22.7%. This was currently being reviewed to ensure that non-clinical and clinical components of the role were split out and recorded. Specialist midwives provide expert midwifery care to groups of women with additional support needs, for example women with diabetes, younger women, those with mental health issues, or substance abuse issues.

Maternity

Feedback from staff was that the antenatal/postnatal ward was constantly being 'pulled' away to support other areas, this impacted on both midwives and medical staff. Staff from triage 'get pulled to work elsewhere and seen as resource pool'. Staff gave an example of a midwife being left on their own in triage with 12 high risk women waiting admission.

Following a meeting with the Royal College of Midwives, staff had raised concerns about on call rotas. There were 2 midwives on call per night and on 4 out of 7 days, staff were called out and used frequently with no specialist team included on the on-call rotas.

In the community, staff told us day to day staffing was often difficult to manage due to vacancies and on-call cover. There was 4 to 5 midwives on-call during the day and 2 to 4 at night. Community staff were pulled to cover the labour wards which impacted on the service because midwives were not available for their planned work in the community the following day.

Some women were not seen at home at all during the postnatal period. Women had raised concerns they had to attend clinic for day 5 (especially those who had a caesarean section or instrumental delivery). Women also raised concerns about the lack of continuity in the postnatal period in seeing the same midwife as during antenatal care.

William Harvey Hospital supernumerary (not counted as part of the staffing required) midwife status was monitored, and this was near to the trust 100% compliance rate. Data from the maternity dashboard from May to October 2022 showed that in June and July 2022 this was at 92%, with slight improvement in other months averaging at 95%.

There were six community teams: Canterbury, Coastal and Thanet based at Kent and Canterbury Hospital, Ashford, Dover and Folkestone and were supported by 2 matrons. The coastal team did not currently have a permanent base.

At the time of our inspection, the community midwife service had vacancy rates of 7 whole time equivalent (WTE) staff, and there were 10.4 on maternity leave. Recruitment for band 6 rotational community midwives was ongoing. Managers calculated and reviewed the number and grade of midwives and midwife care assistants for each shift in accordance with national guidance. The duty rota for the week of the inspection showed the labour ward was on average 4 staff short each day.

Managers were aware of staff vacancies and told us they were working at reducing the vacancy rates, but band 7 midwife vacancies were harder to recruit into. The service had lost a number of band 7 midwives in the last couple of months. Out of the 3 band 7 midwives previously in post. One has returned to her post, and two have subsequently left. The vacancy rates impacted on staff and the support they received to safely care for women and babies. Although staff shortages were escalated, staff said at handover, the senior manager on call for midwifery was not fully aware of staff shortages at night. This impacted on how shifts were managed and staff availability as absences were not identified in a timely way.

Managers used a combination of their own staff, bank and agency staff to cover the shortfall in staffing numbers. All bank and agency staff followed an induction to understand the service.

The service accommodated student midwives who were a valuable part of the staff team. However, the students had raised concerns about not being able to attend the labour suites due to over exposure to nitrous oxide, a gas used to control pain during birth. This could impact on the number of practice hours they needed to meet their learning requirements and graduate. This could have a knock-on effect on the workforce of the future. The trust told us they worked with individual student midwives affected to ensure their safety. Actions were agreed with the university.

Maternity

Staffing was split between triage and day assessment, this consisted of two midwives for triage, one who undertook telephone triage, and one midwife care assistant. There was an administration post which was vacant. There was at times only one midwife at night covering triage and they were sometimes pulled to support labour ward. Staff said there should be doctor cover for triage, however this did not happen, and women were not seen in a timely way if they required a medical review.

Managers said staffing had remained challenging; however, analysis of workforce data had provided assurance that 1:1 care was being achieved across maternity services.

Following our inspection, we imposed conditions to ensure the service implements an effective system for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm, and there is appropriate escalation to provide the right care and treatment.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. The service was reliant on locums and did not have appropriate cover on rotas.

The service did not have enough medical staff to keep women and babies safe. There were several vacancies at all grades including three consultant posts. The trust told us two specialist doctors had been shortlisted and interviews were undertaken in December 2022. Specialist doctors are doctors who have received advanced training in a specialist field of medicine to become a consultant. Other issues included consultants who were unable to cover on call duties due to personal circumstances and this was being managed. The trust had a heavy reliance on locums to provide cover. There were two agency locums in post and ongoing discussion regarding options to cover in the short and long term.

The service always had a consultant resident on site during evenings and weekends. There was one consultant providing cover, however there was no one rostered as second consultant on call. Senior managers told us this was managed on an as and when needed basis. This meant, the trust could not be assured appropriate cover would be available in an emergency. We reviewed evidence indicating potential harm to a woman had occurred because a second on call consultant was not available in an emergency. The trust monitored incidences of non-attendance by consultants.

There was no dedicated medical cover for triage and the postnatal ward. For example, on the day of inspection at 4pm we found there were six women waiting to go home. One was waiting for medication and the other five waiting for medical review. Lack of dedicated cover meant there was a backlog on transfers to the antenatal/postnatal ward and admission to labour ward, which impacted on care and treatment.

We raised medical staffing concerns with the trust following our inspection, and asked them to take action to safeguard women and people receiving care. The trust response was that they had reviewed their staffing and developed a job plan. Two new consultants had been appointed and would have triage sessions in their job plans, and existing consultants' job plans would be amended to cover triage.

Managers could access locums when they needed additional medical staff. Agency locums were currently being used to cover for specialist doctors' vacancies. Locums had an induction to the service before they started work.

The service had a skill mix of medical staff on each shift and reviewed this regularly. We encountered an incident during the inspection where a doctor was unable to carry out a procedure. The consultant was responsive and supportive to the doctor and alternative arrangements were made with plans for training and supervision.

The paediatric senior house officer (SHO) had the responsibility for all baby reviews on the wards. Midwives stated that newborn and infant physical examinations were not a priority, which caused considerable delays in discharges for mothers and babies. There were sometimes two SHOs on duty, but this did not happen very often.

Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm, and there is appropriate escalation to provide the right care and treatment.

Records

Staff did not always maintain complete detailed records of women's care and treatment. Records were stored securely and easily available to all staff providing care. Paper records were not kept securely in handheld records causing a risk they could be lost or mislaid.

The trust used a combination of paper and electronic records, but they were mostly in paper formats. This posed considerable challenges with risks of gaps in record keeping and duplication of entry information in multiple areas, which was time consuming and not the best use of staff resources. The head of midwifery told us they were looking at updating the paper forms with the booklets from the perinatal institute. Women's notes were multidisciplinary, and all staff could access them. The electronic patient record was used to hold information on antenatal appointments, blood test results, scan results and the delivery of babies.

We found record keeping was not well managed and important information to support effective and safe care not consistently recorded. We viewed 11 sets of women's records which included diagnosis, consent forms and evidence of multidisciplinary input. Management plans for women, BMI, and venous thrombosis (VTE) blood clots assessments were not fully completed. Trust data showed that on admission to the labour wards, 52% of women did not have management plans and the situation, background, assessment and recommendation information (SBAR) for postnatal women was incomplete.

Staff did not always maintain accurate records of women's care. Following the inspection, the trust submitted data between 1 January 2021 and 31 March 2021 where a sample of 80 inpatient and community records were audited. This showed 13% of women had a documented 34-week place of birth discussion completed. The management plan for labour and birth was complete in 23% cases. VTE and SBAR assessments were not completed in 60% of the records. The trust used the SBAR tool which is a structured communication format that aids information to be transferred accurately between individuals.

The paper records were not always maintained safely and in line with General Data Protection Regulation (GDPR). We found records contained loose sheets, which included CTGs, and multidisciplinary records. This posed high risks of essential records being mislaid or lost as records were not filed securely and could get mixed up with other women's records or not being available when needed.

In the community, records were handwritten then scanned due to many connectivity issues in the area. Midwives scanned these forms at the children's centre clinics depending on if there was a scanner available. We were told access to scanners and electronic systems was often problematic. The complex birth proforma was currently under review.

The trust was taking actions following the outcome of the records audit. They planned to audit twenty sets of notes to be reviewed each month at each site, with all staff participating in the audit. The first audit report for maternity record keeping was due by the end of March 2023.

Maternity

When women transferred to a new team there were no delays in staff accessing their records as copies of paper records were provided. Women held their own paper maternity records which they used throughout the pregnancy and recorded information from appointments. These were in addition to the hospital recording system. These included information about their pregnancy, screening, pain relief and birth choices.

Staff gave women a 'child health record' on discharge to keep records of their baby's growth, development and for use in the community and transfer between services. Midwives checked with women prior to discharge that they had their child health records.

The electronic patient record identified vulnerable women by a flagging system. For example, women at risk of domestic abuse, and women with mental health needs and any safeguarding concerns.

Computers were password protected to minimise the risks of unauthorised access to women's records.

Staff updated women and baby information prior to discharge, including feedback sent to the community midwives, social workers, and discharge summaries to GP surgeries. This ensured the care of women continued after discharge.

Medicines

Staff followed systems and processes to prescribe and administer medicines. However, the discharge process and monitoring of prescriptions were not always effective, and the pharmacy service only provided a limited service to the unit.

Maternity staff reviewed each woman'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.

Staff told us some women were discharged without their discharge medicines as they were not available at the point of discharge. We saw on the ward several bags of discharge medicines waiting for family members of the discharged women to return to collect the medicines. Therefore, we were not assured the discharge process was effective or timely for these women and their families.

Staff completed medicines records accurately and kept them up-to-date. However, 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 stored and managed medicines and prescribing documents safely. However, the process for monitoring the use of FP10 prescriptions was not effective, as it did not highlight unaccounted for FP10 prescriptions. FP10 prescriptions pads are used to prescribe medicines for patients receiving NHS care. These are controlled documents and all those with access must be made aware of the need for security. In addition, a system must be put into place to record serial numbers of the forms received and issued. This is essential to ensure that if a pad is stolen or lost the serial numbers of the remaining prescriptions can be notified to the appropriate authorities.

The area allocated for the preparation of medicines safety was not appropriate as it was also the only access to the office used by the majority of ward staff. Therefore, we were not assured medicines and associated stationery were always safely prepared for administration or accounted for.

Maternity

We reviewed maternity medicines incident reports for the period from January to December 2022. There had been 80 maternity medicines incidents reported. Incidents were graded as low or medium, in accordance with the degree of harm to the woman or baby. Staff followed systems and internal processes to record the medicines incidents.

Medicines incidents recorded and assessed as no harm included wrong medications, missed doses of intravenous antibiotics and double doses of antibiotics and wrong prescription.

Safe administration of medicines were not always followed as medicines were left on women's lockers for them to take.

In November 2022, the trust had suspended the use of nitrous oxide with oxygen (gas and air) in the delivery suite at William Harvey Hospital (WHH). This was due to lack of adequate scavenging/ventilation systems exposing staff to high levels of nitrous oxide in the labour suites. The trust stated they had assessed mothers and babies were not at risk of harm. Midwifery staff and midwifery students were deemed at risk due to the increased risk associated with long-term exposure to nitrous oxide. Women were offered alternative methods of pain relief and the option to have their care at the sister unit. A temporary solution was adopted in the first week of December 2022 where nitrous oxide with oxygen was made available to women. The trust had undertaken a review of nitrous oxide exposure and new ventilation systems were being put in place.

Staff told us the pharmacist that visited the unit offered support with medicines, checked drugs and administration charts.

We looked at controlled drugs (CDs) and found these were safely managed. CDs are medicines liable to be misused and requiring special management. Staff completed checks of controlled drugs daily and process was followed for the safe management of CDs.

In theatres, the theatre practitioner held the keys to the drug cupboards to ensure they were safely stored.

In the community, medicines required for homebirths were kept in the bag and changed monthly. Bags seen were well organised and security tagged.

Incidents

The service did not always manage safety incidents well and there were delays in investigations being completed to identify actions and learning. Staff recognised and reported incidents and near misses. Learning from incidents was not always effectively managed.

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. However, we found not all staff reported incidents. For example, staff told us they did not always report instances when staffing levels fell below expected standards. Staff felt continually reporting short staffing had not improved the situation, so they had stopped reporting this. This was a concern that we highlighted at our previous inspection in 2021.

We were not assured of continued compliance, learning and embedded practices in incident management. There were 2 never events which related to retained foreign objects post procedure. Never events are serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place and followed. The occurrence of never events within the obstetric department was added to the maternity risk register. Managers shared learning about never events with their staff although staff were unsure whether this was trust wide.

Maternity

When we looked at the outcome investigation into a never event that occurred in June 2022, we saw practice put in place following a previous incident was not embedded. In addition, staff were not familiar with the area did not receive adequate induction or supervision. At our previous inspection, we found staff who were asked to work in areas they were not familiar with reported having a poor induction or orientation, leaving them under prepared, which affected their ability to perform effectively and safely.

Staff reported serious incidents (SIs) 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 harm. 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.

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.

Between September and November 2022, the service had declared 646 incidents and 9 serious incidents. The severity of an incident was graded using the National Patient Safety Agency framework; these were no harm, low harm, moderate harm, severe harm. The majority was rated as low/no harm. There were 6 SIs where currently no investigations had been completed. Incidents were not investigated in a timely way because the trust had a backlog of incidents which had not been investigated.

Other incidents such as staffing and acuity of patients were raised with team leads, however staff did not report them as incidents. Incident reporting was not consistently adhered to, and staff told us this was due to acuity and staffing and therefore this was not considered as priority. Managers provided some debriefs and supported staff after any serious incident.

A key risk for the trust was the capacity and competency within the care group to complete root cause analysis (RCA) investigations in a timely manner to understand what went wrong and reduce the risk of recurring harm and learn from them.

SIs related to maternity clinical care that met the criteria were referred to Healthcare Safety Investigation Branch (HSIB) who were undertaking investigations. All cases referred to HSIB were automatically declared as an SI. Between August 2022 and 10 January 2023 there had been no referrals to HSIB.

There was evidence processes were being developed as a result of feedback from incident investigations. Key learning themes had been highlighted which related to completion and documentation of holistic assessment, senior clinical oversight and management of care, handover and escalation of care and pain relief for women. Managers stated the workflow was being prioritised with key resources allocated to achieve this.

Staff understood their responsibilities under the duty of candour and the need to be open and transparent with women and their families. They told us they would offer the woman an apology and raise any concerns with their line managers who they thought would initiate the duty of candour process.

The service was developing processes to share feedback from investigation of incidents, both internal and external to the service. Trust wide learning was in its infancy and managers said they were working towards improving this.

Maternity

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. Staff protected the rights of women subject to the Mental Health Act 1983.

Maternity services had policies to plan and deliver care according to evidence-based practice and national guidance. However, we found not all policies had been reviewed and updated to reflect current guidance and best practice. This included antenatal screening and antenatal appointment schedule for women with diabetes. Anti-microbial drugs used for neonatal patients were all due for review in 2022 and antenatal transfer from community settings midwifery led unit and home was due in October 2021. When guidelines are not up-to-date, this risks staff not following policies and procedures that reflect current and up-to-date practices. Managers told us they were aware of this, and they told us they were in the process of completing this update.

Women's care was provided in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 22. This standard covered the care of women up to 42 weeks of pregnancy. This included antenatal care in community and hospital settings.

Women who needed a caesarean section (CS), whether planned or emergency, also received care in line with the NICE recommendations QS32. For example, quality statement 1: Vaginal birth after a caesarean section (VBAC).

The maternity service had guidelines for monitoring fetal growth from 24 weeks by measuring and recording the symphysis fundal height as highlighted by MBRRACE-UK (2015) and in line with current NICE guideline (NG201). There was a clear escalation policy and pathway for any abnormal findings.

The policy for fetal monitoring had been reviewed and updated in May 2022. The policy was amended to include additional information around meconium stained liquor and short-term variation (STV) sticker from Dawes Redman review.

There were pathways for women with mental health needs. The pathways also contained telephone numbers for community mental health teams, for advice and support in a timely way.

Nutrition and Hydration

Staff gave women enough food and drink to meet their needs and improve their health. Mothers and families were well supported to feed their babies.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women told us staff had provided them with breastfeeding advice and support and the need for them to keep hydrated.

Maternity

Breast feeding initiation rates were rated green on the maternity dashboard from September to November 2022. Breast feeding rates had fluctuated through the year and were at 68% in November 2022, an action plan was being developed to meet the UNICEF Baby Friendly Initiative recommendations. This included introducing 1:1 antenatal feeding conversations with pregnant women, exploring what women already know and offering further information, as per UNICEF Baby Friendly Initiative recommendations.

Patient information on breastfeeding support was available to women in the department. Women we spoke with said they had received support to breastfeed soon after birth, and this had continued on the postnatal ward. A choice of formula milk was provided to mothers who needed to bottle feed their babies.

Maternity offered a breastfeeding room and had a breastfeeding midwife to support women. The breastfeeding room had a fridge to store breastmilk and if women wished to bottle feed, sterilisers were readily available. Support workers were trained to support women with feeding their babies.

The breastfeeding support team provided a good service to women. The team consisted of 3 band 3 health care assistants and a lactation consultant. They were responsive, supportive and available 7 days a week and supported women in the unit and also followed mothers and babies at home.

Data from the trust on infant feeding showed there was poor documentation about antenatal feeding, and this included feeding assessments both on the wards and community services. In 77% of records there was no feeding assessment completed, and in the community this ranged between 44% and 89%.

Ward based staff were receiving training to provide appropriate support, including promotion of skin-to-skin contact, via the infant feeding day in the mandatory block training week. Lactation consultants had been employed on both acute hospital sites to educate and support staff in relation to infant feeding. The measure used for breastfeeding initiation within the trust was ‘breastfeeding at first feed.’

Pain relief

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

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice, before and after birth.

Staff used a universal pain assessment tool to assess the level of women’s pain on the ward. We observed staff asking women about their pain and women we spoke with on the ward told us their pain was managed well and in a timely manner.

Women received pain relief soon after requesting it, and women commented they received advice on pain control and told us their pain control was ‘good’.

Staff prescribed, administered and recorded pain relief accurately and this included use of different methods of pain control such as patient controlled analgesia and nitrous oxide, such as Entonox.

Maternity

In November 2022, nitrous oxide (gases such as Entonox used for pain relief during childbirth) was temporarily withdrawn from use at the hospital due to issues with ventilation. This meant women would not be able to be given full choice of pain relief during childbirth. Women were offered alternative methods of pain relief and also given the options to give birth at the QEQM site. At the beginning of December 2022, the use of nitrous oxide was back in place in labour suite.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They used audit findings to make improvements. However, outcomes for women were not always positive, consistent and met expectations, such as national standards.

The service participated and submitted data to the national clinical audits. The dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs). 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.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The audits programme was being further developed, managers shared and made sure staff understood information from the audit and the improvements needed.

During November 2022, the overall rate of 3rd and 4th degree perineal tears was noted to be 3.8%, a 0.2% increase from the October. A perineal tear is a laceration of the skin and other soft tissue structures which, in women, separate the vagina from the anus. The overall rate remained slightly higher comparatively to the neighbouring trusts within the local maternity and neonatal systems (LMNS). The trust had declared there had been no noted significant themes. A local audit had been commissioned to review and identify themes or learning. The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, 'Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29), 2015,' state the "overall incidence in the UK is 2.9%."

The trust performed better than or in line with the national standards. For example, women who received 3rd or 4th degree tears at delivery, the most recent National Maternity and Perinatal Audit (NMPA) data (Aug 21 to July 22) showed the trust had an average of 3.3% against the national average of 3% (with an expected range of 2.4% to 3.6%). The trust had a rate of 2.0 compared to the national average of 2.8 women who had a postpartum haemorrhage 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.

Between September and November 2022, there were 1610 babies born at the service. During November 2022 there were two reported stillbirths, both cases were being reviewed through the perinatal mortality review tool (PMRT) process, with parent perspectives to be included.

The trust participated in the National Maternity and Perinatal Audit (NMPA), this found the trust performed worse than average for the overall caesarean rate and proportion of all babies at term who are <10th centile, who are born at after 40+0 weeks. All other indicators were in line with or better than the national average.

Maternity

Managers and staff used the results of audits to improve women's outcomes. The service had a maternity dashboard which included patient outcome indicators. For example, spontaneous vaginal delivery rate, category 1 caesarean 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.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Staff completed additional training to maintain their registration with the Nursing and Midwifery Council (NMC).

Managers gave all new staff an induction tailored to their role before they started work. There was a six-week induction programme which comprised of e-learning and clinical observation of practice for all new starters. Staff were allocated time on the wards and in the community and agreed probationary objectives were set with the line managers. Induction training included cartograph (CTG), PROMPT, fetal monitoring and infant feeding.

Managers and professional midwifery advocates (PMA) supported band 5 midwives' clinical competencies, these included administration of oral medication, administration of intravenous (IV) medication, epidural infusions, bereavement care, maternal resuscitation and cardiotocography (CTG) interpretation. CTG is a means of recording the fetal heartbeat and the uterine contractions during pregnancy.

Staff told us they were supported with revalidation with their professional bodies. For example, the NMC or the Health and Care Professions Council (HCPC). Staff we spoke with told us mandatory training compliance and revalidation was always discussed as part of their annual appraisal. The midwifery appraisal rate was below the trust target of 85%. The data showed this was between 73% and 74% compliance as of September and October 2022. The latest data for November 2022 was not available.

The infant feeding and tongue tie support team delivered training for the whole midwifery team.

The trust had started to implement the Maternity Support Worker (MSW) Competency, Education and Career Development Framework to ensure that MSWs can achieve standardised levels of competency required to carry out this role.

In the community the MSWs ran the 'Pre-booking' clinic, taking bloods and conducting standard observations. They supported the midwives in a variety of roles including some administrative tasks.

The professional midwifery advocate (PMA) role was not embedded in the community services as staff were unsure who they were and what their roles entailed. PMAs are experienced midwives with additional training who support the practice and professional development of midwives.

Managers supported nursing staff and midwives to develop through regular constructive clinical supervision of their work. The clinical educators supported the learning and development needs of staff.

Multidisciplinary working

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

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. In accordance with RCOG 'safer childbirth' guidelines there were daily meetings following handover on the antenatal/postnatal ward and the labour ward. These involved multidisciplinary staff members including consultants, junior doctors, senior midwives and clinical leads.

There was a weekly clinic held on a Tuesday at William Harvey Hospital led by two obstetric consultants providing care for women with pre-existing diabetes (type 1 and 2) and gestational diabetes. The clinic was delivered by a multidisciplinary team, which included a consultant endocrinologist, diabetes specialist nurses, diabetes specialist midwives and health care assistants.

There were daily situation report cross site meetings with the Queen Elizabeth the Queen Mother Hospital. We observed good collaborative work and the meetings used a similar format where acuity, current staffing and next 24 hours, number of women in labour and capacity in neonatal intensive care unit was discussed. The community team had the opportunity to contribute where staffing, on calls, home births actual and potential were discussed.

There were monthly meetings between ultrasound staff and the fetal medicine consultant, screening midwife, senior midwifery staff and community midwives to review women's antenatal imaging.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred women for mental health assessments when they showed signs of mental ill health or depression. However, staff told us there was no cohesive working between triage and labour suite.

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 depending on the care pathway.

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

A consultant obstetrician was present from 8am to 8pm. The service had a consultant resident on site after 9pm during weekdays and at weekends. There was no consultant rostered as a second on call person which was of concern as staff relied on 'good will' when needed for providing emergency cover.

There was one obstetric theatre and one general theatre available to maternity services.

Pathology, diagnostic services/ultrasounds and pharmacy services were available Monday to Friday 9am to 5pm. All these services provided out of hours cover and urgent responses when needed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the wards and in the community. Information leaflets included smoking cessation support, healthy eating and raising awareness about kick counts. The Rising Sun Domestic Violence and Abuse service supported women and children in the local community. Midwives discussed nutrition and weight as well as accessing appropriate vaccinations. Women were encouraged to have recommended vaccines such as influenza, rubella and whooping cough.

Staff assessed women's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff told us they followed the 'Saving Babies' Lives Care Bundle'. This was an initiative from NHS England (NHSE) to reduce stillbirths and early neonatal deaths. The four elements of care are: reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement, and effective fetal monitoring during labour. Women had their carbon monoxide reading taken at booking and audit data in December 2022 showed compliance was 96%.

During their antenatal booking appointments women had a carbon monoxide exposure test and women received advice and support including referrals to the smoking cessation service.

A 'child health record' was provided to parents for each baby prior to discharge from hospital. This was a parent held record and parents/carers were encouraged to record health information in this book and have it available during appointments with other health professionals.

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 followed the trust consent processes and knew how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and this was recorded in some women's records we reviewed. We saw evidence of this being recorded when women had refused particular care or tests.

When patients could not give consent, staff made decisions in their best interest, considered women's wishes and culture. Staff made sure women consented to treatment based on all the information available. Staff completed training and study days in the Mental Capacity Act 2005.

The trust told us they did not have a specific 'consent audit', they shared an audit titled 'Risks of Surgical Management of Miscarriages Documented on Consent Form' which was currently at the reporting stage. This consisted of two cases, the first one dated back to 2021. The other was started in March 2022, there was evidence these had been chased for updates and actions not completed. The trust told us the audit was due to be presented at the audit day on 17 Feb 2023, after which an action plan will be developed.

Staff understood the use of Fraser guidelines in relation to children. This is a legal ruling whereby clinicians may accept consent from a child under 16 years of age, who has been assessed as competent to understand the implications of consent.

Maternity

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. Midwives supported children who wished to make decisions about their treatment.

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 were at times compromised when receiving care.

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. Women said staff treated them well and with kindness. Staff took time to share information with women about their care.

Staff followed policy to keep women's care and treatment confidential. Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

The maternity friends and family test report showed that 93.6% of patients recommended this hospital.

Comments included, "Staff were brilliant, calm and informal but in a professional way which just put us at ease." "We felt really, really supported for those 5 days after the birth that we were in. Most people would hate to be in hospital for that long, but we were actually really pleased we were there, particularly with breastfeeding support."

Other women said they received reassurance through the whole labour process with constant reassurance and were grateful for the care and support.

We found that at times 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. This included walking in the corridors in blood stained gowns and having to use bedpans as the toilet was in the corridor. There was no showering facility which for some women would be distressing as getting in a bath would be seen as unclean.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff supported women who became distressed and ensured there was a private area for breaking bad news and provided emotional support.

Maternity

Staff had not considered the emotional impact of removing babies requiring emergency care from the labour rooms to resuscitaires and the anxiety this would cause women to be separated from their babies.

The bereavement midwife had the skills and completed training on breaking bad news and demonstrated empathy when having difficult conversations. Staff were focused on women's needs and women were referred for psychological and counselling support. The bereavement midwife was passionate and went the extra mile to support women. However, the team consisted of one midwife to provide this service.

The perinatal quality compliance report highlighted compliance of 4 hourly observations when the women were going through the induction process in the bereavement suite. Action plans were developed as part of the mandatory bereavement update and was being addressed. The trust told us the bereavement midwife was in the process of developing a 2 minute 'take away' recorded video to be shared with staff regarding learning points. We did not see any evidence of this when we spoke to staff.

The patient story to board in November 2022 highlighted the need to improve the bereavement suite at the William Harvey Hospital. There was one bereavement midwife to follow up with women. Following the Ockenden report, the trust undertook a gap analysis, an action plan was developed to review recruitment, and investment into bereavement care had been agreed. The Ockenden report was commissioned by the secretary of state as an *independent review of maternity services following several neonatal deaths and to support improvements in the maternity service.*

Women were supported to access psychological and the mental health team as needed.

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. Women told us staff had involved partners in their care with their consent. Staff talked with women, families and carers in a way they could understand.

Women gave positive feedback about the service. Women and their families we spoke with were happy about the care they had received and were complimentary about the support from staff.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. The maternity service undertook a survey of women about six weeks post-delivery to gather their experiences of care (Your voice is heard).

We reviewed the data from November 2022 for the trust patient survey which showed there was a 70% response rate. Women had a 91-93% positive response about their antenatal and labour care and 81% were positive about their postnatal care.

The trust took part in the NHS 2022 maternity survey. The top 5 positive responses included information about induction of labour and support during labour. Women felt confident in being able to contact the appropriate team if they needed support with their mental health needs.

Areas where the trust did not perform well in were within postnatal care, such as when partners or carers want to stay with the women, and support with feeding babies during the nights and weekends.

Maternity

Staff supported women to make informed decisions about their care. Data from the November 2022 women survey showed 282 women said they were included in making decisions about their care, 27 said they did not feel included and 24 stated they were sometimes included. Information was shared with women and staff ensured they understood them. Comments from women included how staff were “incredibly supportive to both myself and my partner during this difficult and scary time. During our stay on both wards, we were continually supported by the midwives and nurses.”.

Is the service responsive?

Inadequate ↓↓

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

Service delivery to meet the needs of local people

The service did not always plan or provide care in a way that met the needs of all local people and the communities served.

Managers planned and organised services however they did not effectively meet the needs of the local population. The labour ward, antenatal and postnatal ward were open 24 hours a day, seven days a week. The service provided a patient triage telephone line 24 hours a day, seven days a week for patients to speak to a trained midwife about any concerns they may have. However, the midwife led unit at the hospital had been closed for over 18 months and there was no plan for this service to be resumed.

Facilities and premises were not always appropriate for the services being delivered. The fetal medicines service did not effectively meet the needs of women because the ultrasound service comprised of both obstetric and non-obstetric ultrasounds. The service was fragmented, not women centred and fell short of achieving holistic care and support for women throughout their pregnancy. At the time of the inspection there was no fetal monitoring midwife, managers told us that someone had been recruited into this post and was waiting to start.

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 needs.

The service was not set up to support all women who had complex needs. Managers told us they did not have a maternity learning disability midwife lead to support women and their babies. Staff did not know how to access support for women with a learning disability.

The service had systems to help care for women in need of additional support or specialist intervention. Maternity services did not have an intensive care unit facility and women were transferred to the general ICU as needed. The unit had a neonatal intensive care unit (NICU) close to the labour wards to care for babies requiring additional support.

Maternity

Midwives monitored and took action to minimise missed appointments and ensured women who did not attend appointments were contacted and rebooked.

Meeting people's individual needs

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

Staff made sure women living with mental health needs received the necessary care. However, there had been an increase of patients with learning disabilities and autism and there was not a dedicated maternity learning disability midwife to support women and their babies. Some staff told us they worked with the voluntary sector to try and support women with complex needs.

The trust had two learning disability nurses who sat within the safeguarding team and were looking to expand safeguarding to include a homelessness team. This was particularly high need for one of the community services. However, it was unclear on how this would evolve and impact the maternity services.

There had been a rise of post-COVID mental health concerns in women. Trauma midwives had been offered training in mental health first aid to support these women.

The service facilities were poor and did not meet the needs of women and their families. The delivery suites did not have ensuite facilities which meant women had to access washing facilities and toilets in the corridor and there were no showers. There were two bathrooms to accommodate 12 women. This impacted on the care, privacy and dignity of women using the service. A business case had been submitted for capital funding for environmental improvements.

The "twinkling stars" bereavement room was in the day assessment and triage area. The room was equipped with ensuite facilities, nicely decorated and furnished to a very good standard to include a double bed, small kitchenette and microwave. However, this was in the day care, fetal medicines and triage area which meant women had to access this room where other women and babies were present.

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.

Access and flow

Services were not effectively planned and accessible to meet the needs of women. There were delays to discharges and these were not monitored. The midwife led unit was not available to women.

Women could not always access all of the services when needed or receive treatment within agreed time frames and national targets. Midwifery led units were not always accessible to women. The trust had closed their midwifery led unit for the past 18 months. Women were offered limited choices, and this resulted in women travelling over 50 miles to access services. The trust received 18 complaints from women in October 2022 due to women having to give birth elsewhere.

Maternity

We found there was a lack of understanding about the effects of limited choices among some senior staff. The trust had declared intermittent and temporary closure of the home birthing service alongside the midwifery led unit.

Homebirth services were not always accessible for women. Trust data between January and December 2022 showed the homebirth service was open 57% of the time, open with restrictions 5.6% of the time and suspended 19.4% of the time. For the 18% there was no data available.

Managers did not monitor the number of women whose discharge was delayed and therefore did not identify actions or learning to reduce delayed discharges. For example, there was a lack of dedicated medical cover and Newborn and Infant Physical Examination Screening (NIPE) trained midwives which impacted on discharges as women waited longer than necessary for their reviews and babies' NIPE assessment. The NIPE screening identifies abnormalities in eyes, heart, hips and testes and should ideally take place before 72 hours of age. For babies born in hospital, it is recommended the examination is completed before transfer home. The delays impacted on movement in the labour ward as women could not be discharged to the postnatal ward.

At the time of inspection, there was no standard operating procedure for the induction of labour. This was discussed during the morning and evening multidisciplinary handover meetings. We received concerns from members of the public relating to communication around induction of labour. These have included lack of communication about when they will be requested to attend the hospital, or multiple cancellations.

The timeliness and effectiveness of processes in triage was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm. A triage service was open 24 hours a day, seven days a week for women who were experiencing pain or symptoms from 16 weeks of pregnancy. If women had concerns about their pregnancy before birth or post-natally, they could contact the maternity triage. The service had pathways of care for specific conditions which triage midwives followed. However, we found women spent prolonged periods of time in triage. This meant women were not always cared for in an appropriate environment due to challenges in managing flow across the maternity unit. For example, we saw women experienced delays to move onto the labour ward or Folkestone ward for antenatal care due to lack of available beds.

The trust was exploring how best to provide the obstetric fetal medicine service, which would be dedicated to maternity without the competing capacity concerns currently seen. The proposal would give maternity services the ability for them to manage the whole obstetric ultrasound service and have the flexibility to adjust provisions in line with requirements, recommendations and guidance. The fetal medicines service was not responsive to the current needs of women using the service.

When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

There was one outlier on the medical ward at the time of the inspection and maternity staff ensured they received appropriate obstetric care and follow up.

Staff planned women's care and discharge, particularly for those with complex mental health and social care needs. Staff supported women and babies when they were referred or transferred between services.

Following our inspection, we imposed conditions to ensure the service implement an effective system for assessing, managing and monitoring the safety and timeliness of discharge to keep women safe from avoidable harm and to provide the right care and treatment at the maternity department.

Maternity

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. 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.

Women, relatives and carers knew how to complain or raise concerns. Information on how to raise a complaint was available on the trust website, although this was not clearly displayed in patient areas we visited.

Staff understood the policy on complaints and knew how to handle them. They were confident in raising any complaints from women or their families with the team lead, matron or the midwife coordinator.

Maternity services had received a low level of complaints, between September and November 2022 there were 20 complaints received. Managers investigated complaints and identified themes. The complaints related to delays in treatment, communication/information. Time frames for responding to complaints were monitored and 4 out of 5 had been breached in November 2022 due to delays in obstetric input.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used women's feedback to improve daily practices. The service had listened to women and their relatives and made changes.

Is the service well-led?

Inadequate 

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

Leadership

We were not assured that leaders were aware of all the risks and challenges at the service. They were visible and approachable in the service for patients and staff.

The service had a clear management structure. It was led by the clinical director, director of midwifery, and operations director. This leadership style was referred to as a triumvirate. Members of the triumvirate had clear roles and responsibilities. The triumvirate had regular meetings to discuss activity, finances and the maternity improvement plan. There were two heads of midwifery, one based at each acute hospital.

Leaders had the skills, knowledge and experience needed to run the service. However, all members of the triumvirate were in interim roles. The trust has reviewed the maternity structure and recruited a deputy director of maternity. When we spoke to the trust about the interim posts, they told us they felt this was “a young team which needed to grow, and not all staff were ready for permanent roles”.

Leaders were not always aware of the risks, issues and challenges in the service. Leaders understood some of the issues the services faced, such as concerns around the estate and lack of neonatal emergency equipment (resuscitaires) in

labour rooms. They could not demonstrate adequate systems and processes to provide assurance that they had full oversight of the service in terms of risk, quality, safety, and performance. 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.

There were systems in place to monitor services. There were systems that allowed risks to be escalated to the trust board. The trust's new chief nursing officer was the executive lead. A non-executive director (NED) had been appointed. Their responsibility was to work collaboratively with the board level safety champion in chairing the maternity improvement committee and Clinical Negligence Scheme for Trusts (CNST) review panel.

The chief nursing officer held weekly meetings with the director of midwifery to provide ongoing support, guidance and review services and oversee improvement and action plans. The chief nursing officer met monthly with the regional midwifery officer.

Staff felt supported by their immediate line managers, despite feeling under intense scrutiny due to the independent external investigation into maternity and neonatal services at the trust. The investigation followed a number of neonatal deaths and the safety of maternity care at the trust, a report was published in October 2022.

Senior managers had confidence in the leadership teams in working together and "supporting and encouraging honesty" and moving to be clinically led. The leadership team felt that recent scrutiny had been upsetting and they were working on building the team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. 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.".

The values for the service 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 realistic 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:

- Women and families,
- Quality and safety,
- Our people,
- Our future,
- Our sustainability.

These were aligned to the trust's overall priorities. The service said the strategy was developed with relevant stakeholders such as women and their families and staff.

Maternity

Staff did not know and understand what the vision and strategy were, and their role in achieving them. Most of the staff we spoke with did not understand what this was for the maternity department.

The service had been part of an independent investigation into its maternity and neonatal services. 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 the 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.

Culture

Staff did not always feel respected, supported and valued. There were low levels of staff satisfaction, high levels of stress and work overload.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff had a strong attachment to their teams. They told us they felt valued by their immediate line managers.

There were low levels of staff satisfaction, high levels of stress and work overload. Morale was low amongst staff who felt they did not always work well together, for example, some staff expressed poor collaboration or cooperation between teams meaning they felt they worked in 'silos' and did not feel part of the wider organisation or service. Staff told us they did not always feel supported by their peers from the other acute inpatient site and described a poor working relationship with them.

We heard on several occasions where staff had refused to move from the Queen Elizabeth the Queen Mother Hospital to the William Harvey Hospital to help with staffing, meaning they were unable to deliver effective and safe care to women and babies. When we spoke with senior managers, they confirmed that there was no staff movement between the two acute sites, and this was due to working relationships and culture within the services.

The latest staff survey showed 46% of staff who would recommend the trust as a place to work and 52% would be happy with the standard of care provided by this organisation.

Staff did not always feel comfortable to raise concerns if they were unhappy about how services were managed. There were concerns raised by some staff that the trust did not have an effective zero tolerance process to manage disrespectful and rude behaviours from some senior staff, including doctors. We heard examples of staff not being

treated with respect and feeling undervalued. Although these were raised with senior managers, staff said there was no action taken. This did not encourage staff in reporting abuse and bullying or trust this would be managed effectively. This resulted in a lack of respect and trust between staff and failure to work effectively together which may indirectly lead to poor care.

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. Senior managers told us they had performance management procedures in place which can at extreme end in dismissal.

Junior doctors had highlighted bullying behaviours, feeling unsupported and unsafe, this was reported in the General Medical Council survey. As a result, a meeting was held with all consultants in December 2022 to discuss this feedback. The trust reviewed the Royal College of Gynaecology (RCOG) standards and behaviours for on-call arrangements, elicited some external support from another trust and the trust's chief executive wrote to all the consultants.

Performance in the 2022 General Medical Council (GMC) National Training Survey (NTS) scored below (worse than) the national aggregate for 'overall satisfaction', these were for 'reporting systems', workload', 'teamwork' and 'educational governance'.

Canterbury Christchurch University had removed student midwives and they were no longer allocated to the service as part of their student placements.

The trust had appointed a Maternity Freedom to Speak Up Guardian (FTSUG), who was available to all members of staff. The contact number was available on the trust internet. Staff members we spoke with were aware of the role, however they told us they had not used this service.

The service served a population which was predominantly White with some pockets of deprivation. The Workforce Race Equality Standard (WRES) data report for 2021-2022 showed most staff groups were predominantly White. The trust had increasing numbers of staff from ethnic minority groups due to recruitment of internationally educated nurses and doctors.

The WRES report showed that representation of staff from ethnic minority groups at board level was not representative of the workforce.

Although clinical staff at band 5 had higher ethnic minority representation at 41%, this was below 10% for staff in the higher grades.

Staff from ethnic minority groups and disabled staff had a higher likelihood of entering the disciplinary process. This had changed in trend from previous years. The trust had declared there had been a 6.8% reduction in staff from ethnic

minority groups experiencing harassment, bullying or abuse from patients/service users, relatives or the public. However, the percentage of staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months was significantly higher for staff from ethnic minority groups at 35.7%, compared to 29.4% of White staff. The trust recognised that more work was needed to address these inequalities including pay gap disparities.

The Workforce Disability Equality Standard (WDES) data showed there had been a significant improvement (5.5%) in the number of staff with a long term condition (LTC) experiencing harassment, bullying or abuse from managers, although it remained approximately 10% higher for staff with a LTC (25%) than for those without (15%).

We reviewed the trust action plan against the 2022 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”.

Governance

Leaders did not consistently operate effective governance processes. Governance processes were being developed and were not yet embedded in current practice. Staff roles and responsibilities at all levels had been redefined.

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.”.

Following publication, the trust 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 were committed to addressing the four areas for action that were identified in the independent review, these are:

- Monitoring safe performance
- Standards of clinical behaviour
- Flawed team working
- A recommendation specifically for the Trust to embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

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.

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 have been completed. Progress against the governance action plan was managed and monitored through the maternity improvement plan.

We submitted a request for a copy of the report which NHS improvement had submitted to the trust in October 2022 which identified similar concerns we found during this inspection. We did not receive the report as requested.

Maternity

The challenge for the trust remained as the senior leadership teams were largely in interim roles which would end in April 2023. This posed serious questions on how the trust would be making sustainable changes in their governance and culture with the possible advent of new teams.

The service had a maternity improvement plan with 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. The improvement plan was due to be presented to the trust's board of directors at its next meeting in April 2023.

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.

There was some oversight of serious incidents. A quarterly serious incident report was submitted to the board. Maternity service governance team members attended the monthly integrated care board (part of the local maternity system) and discussed serious incidents. A serious incident panel and quarterly meetings were held with the Healthcare Safety Investigation Branch (HSIB). Staff could not tell us how feedback and learning to the wider team were consistently managed in order to promote sustained improvement, as governance processes was still being developed and not embedded.

There were seven specialist governance midwife level roles including compliance and assurance, audit research, patient safety and lead investigation. These midwives reported directly to the interim governance matron who reported to an interim deputy head of governance for maternity. The staffing structure has some vacancies and was still in the process of being recruited into and embedding. Senior managers told us 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 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 providing executive oversight. It was also attended by the non-executive director who acted as the safety champion for maternity.

The non-executive team attended a monthly MNAG meeting which looked at governance, strategy, serious incidents (SIs) and training and this went to the board monthly.

Local Maternity and Neonatal Services (LMNS), the regional chief midwife and board members held monthly MNAG meetings.

The trust had reviewed the role of the safety champion, including governance processes and key relationships to support full implementation of the quality surveillance model. Safety champions have formalised spot checks to corroborate and challenge the assurance provided at MNAG.

Maternity

The board was responsible for overseeing the programme, with day-to-day responsibility for delivery and monitoring progress taken forward by the Clinical Executive Management Group. Specific improvements in maternity and neonatology services were overseen by MNAG, again reporting to trust board.

Management of risk, issues and performance

The trust identified and escalated some risks and issues and identified actions to reduce their impact. However, we found failures in performance management and audit systems and processes. The trust had some plans to cope with unexpected events.

The maternity service did not always manage safety risks effectively. We identified concerns and risks on inspection, such as triage, second consultants on call for emergency cover, staffing, lack of safety checks for emergency equipment/ resuscitaires, which were not effectively addressed. We raised them as serious concerns during and following our inspection.

The risks of emergency equipment such as no resuscitaires in the labour rooms had not been addressed. There was a real risk of babies receiving sub-optimal care, as delays in accessing vital equipment could impact on babies. The risk had been identified at the last inspection and mitigation has not been effectively managed to ensure safe care for women and babies.

The trust in response to concerns we raised in a letter relating to resuscitaires told us babies would need to leave the labour room for resuscitation. The midwife transporting the baby should firstly ensure the baby was clearly labelled prior to leaving the room and they must stay with the baby. Resuscitation and availability of emergency equipment are time critical and should not be underestimated. There was no standard operating procedure (SOP) as the trust told us this was being developed and was in draft form for consultation. This posed a risk of staff not following a consistent approach when dealing with neonatal emergencies.

The management of risks were at times reactive such as following concerns that we raised following the inspection, the trust actions included employing a dedicated fetal heart monitoring midwife, adding an automated electronic alert for staff when a fetal monitoring check was due. Also increased doctor cover of triage at William Harvey Hospital, and strengthening processes around regular cleanliness checks. These did not appear to have been identified as part of the trust's own regular risk assessments of the service in providing safe and responsive care.

The trust had a backlog of serious incidents (SIs) which had not been fully investigated. This carried risks of SIs which could have severe impact on women and babies, with delays on developing action plans, and learning opportunities being missed.

The governance around policies and guidance for staff was poorly managed. Policies and guidance had not been reviewed and updated in a timely way to ensure staff's practices reflected current guidelines. The trust in response has put in a part-time guideline midwife to review and update the out-of-date guidelines.

The service could not always demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle. The fetal monitoring audit was last carried out in 2021 and presented at audit day April 2022. The trust told us due to the vacancy for a fetal monitoring midwife at the time, delays in progress of audit outcomes had led to three outstanding audit actions. A draft fetal monitoring project plan for ongoing prospective audit was agreed in September 2022, this was not complete at the time of the inspection and trust plan to publish in January 2023.

Maternity

The trust undertook a MEOWS documentation audit between August and December 2022. It looked at a random set of 55 postnatal notes. It showed a low level of compliance of between 26% to 43% in the completion of vital signs on MEOWS charts such as temperature, blood pressure and heart rate. This posed risks of women not receiving safe and effective care and escalation.

Following our inspection, we requested actions which the trust had taken to mitigate maternity risks. The trust returned a maternity risk register dated February 2023. The maternity risk register had identified 24 risks, nine were rated as medium, 10 as low and five as very low.

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.

The trust stated that a workshop and a program of work for embedding patient safety was in developmental stage. Leaflets were in draft form for the governance manager, patient safety lead and lead investigator's roles and responsibilities in SI management.

The trust did not have an induction of labour standard operating procedure, and this was not managed effectively. The labour ward forum was reviewing the induction of labour pathway and to adopt National Institute for Health and Care Excellence (NICE) guidance relating to induction of labour.

The non-executive team had meetings with HSIB teams and used this as a sense check of the trust. They told us HSIB were honest about the quality of reports and management of the reporting process.

The trust was planning for all maternity incidents to be reviewed to ensure they were then moved to the trust wide serious incident panels to investigate. Serious incidents investigations would form part of a multidisciplinary team (MDT) approach and for internal assurance. Work was needed to build this structure, develop the pathway and train staff in order to achieve this.

There was a sense that safety and some risks were being re-enforced through message of the week and team briefs. Following an increase in baby falls on the wards at QEQM site during the night, information was shared with staff about actions which included warning mothers about the risks of falling asleep and dropping a baby whilst feeding. This could be whilst performing a postnatal check and enquiring about fatigue, ensuring the top side bedrails were up and the use of bedside cots.

The trust had submitted a business case on the transfer of the ultrasound service to maternity. Currently the fetal medicines service was not women centred and not fully resourced. The proposed transfer of the service would ensure the long-term goal in achieving a tailored service, providing a holistic care approach and support for women throughout their pregnancy. These proposed changes were aimed at a reduction in clinical incidents due to the limited capacity and misaligned services. There were issues around the capacity for urgent growth scans with increased workload for the maternity triage teams who monitored women who were seen daily until their scan had taken place. However, there was no short-term plan or mitigation to support safe care and meet women's current needs.

This proposed change would enable maternity to develop their own training and education prospectus for midwives to complete their scanning competencies, resulting in midwives being suitably skilled to undertake fetal wellbeing scans.

Maternity

The trust had developed a standard operating procedure for infection prevention and control and auditing. The head of midwifery or matron planned to undertake a clinically led environmental audit with the trust infection prevention and control (IPC) lead. We viewed the trust's infection prevention and control annual report for 2021-2022.

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. There was insufficient coverage of both quality and sustainability. The service was currently on an improvement journey and staff described being 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 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.

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, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The maternity service engaged with women to gain their feedback. In May 2022, the trust launched a pilot project (Your voice is heard) which ran for three months to gauge women's satisfaction about their care. Between 19 May 2022 to 20 January 2023, the patient experience midwives had received and shared 1174 compliments to staff. Patients expressed a high degree of satisfaction with the care they had received. Areas that required improvement were postnatal care which included staffing at night and higher usage of agency staff, noise such as people using phones, lighting and discharge delays due to pharmacy and neonatal doctors' availability.

The last available staff survey showed 46% of staff who would recommend the trust as a place to work and 52% would be happy with the standard of care provided by this organisation.

There were processes which had been developed to engage with people using services. The maternity patient experience midwives worked with the Maternity Voices Partnership (MVP) to discuss service improvements following patient feedback. They attended quarterly MVP meetings to inform the group of service updates, and these were captured in MVP minutes and action logs.

Maternity

Feedback to the patient experience midwives was fed back to management teams for discussion and actions. This was reported via the monthly Perinatal Quality Surveillance Tool (PQST) to trust governance meetings such as Maternity and Neonatal Assurance Group (MNAG) and trust board.

Learning, continuous improvement and innovation

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

There was a focus on innovation and research in maternity. Leaders encouraged learning, improvement and innovation. The service had a maternity improvement plan. The improvement plan had an action tracker to monitor their progress against the actions.

There was a focus on quality improvement, although this was at the start of the journey. As part of the quality improvement and as ICS evolve to become accountable for the quality and sustainability of services. The LMNS will work with the ICS to take on a more formal role in perinatal clinical quality oversight alongside transformation and improvement activity.

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. However, it was not obvious what quality improvement tools the service used to drive improvement.

The trust had submitted a business case on the transfer of the ultrasound service to maternity. The proposal was aimed at the long-term goal for maternity ultrasound service in achieving a tailored service, aiming at a holistic care approach, and support for women throughout their pregnancy.

The service was reviewing their triage process. The trust had implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS). This was not fully developed at William Harvey Hospital.

In collaboration with the local maternity system (LMS) and regional chief midwife, the board were looking at formalising how trust level intelligence will be shared to ensure early action and support for areas of concern or need.

Outstanding practice

We found the following outstanding practice:

- 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:

Maternity

- The trust 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(1) and 12(2)(b)).
- The service must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. (Regulation 12(1)(2i)).
- The trust must ensure equipment for providing care or treatment is safe for such use and regularly serviced. Safety checks must be completed of emergency equipment to ensure it is safe and fit for purpose. (Regulation 12(2)(e)).
- The service must ensure prescription stationery are monitored and accounted for; medicines are stored securely. (Regulation 12(2)(g)).
- The trust must ensure infection control processes and policies are followed to reduce the spread of cross infection. (Regulation 12(2)(h)).
- 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 delays to discharges are monitored and appropriate actions taken to ensure access and flow through the maternity department, including ensuring actions taken to minimise the length of time people must wait for care, treatment or advice. (Regulation 17(a)).
- The trust must ensure it improves its local quality monitoring process and audits and acts promptly where poor standards are identified to protect patients from receiving harmful care. (Regulation 17(2)).
- The trust must ensure implementation of an effective system for assessing, managing and monitoring the safety of women and babies using cardiotocography monitoring and fresh eyes. They must maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and decisions taken in relation to care and treatment. (Regulation 17(2)(c)).
- The service must make sure there is 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. (Regulation 18(1)).

Action the service SHOULD take to improve:

- The trust should ensure incidents are investigated in a timely manner to identify actions and learning. Learning should be shared trust wide.
- The trust should continue to monitor and improve staff compliance with necessary training to include safeguarding and face to face PROMPT training.
- The service should ensure all paper records are securely fastened within women's handheld records eliminating risks of record sheets being mislaid and lost.
- The service should ensure reviews of policies and procedures are completed in a timely way and this is available to staff to support their practice.
- The service should ensure there are effective systems to make sure all complaints ae investigated without delay.
- The service should ensure that women have a choice of place of birth.

Our inspection team

The team consisted of a lead inspector, a pharmacy inspector and 4 supporting inspectors. The inspection team was supported by 4 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.

During the inspection, we visited key areas of the maternity unit; this included the delivery suite, antenatal triage, maternity day care, fetal medicine, and the antenatal/postnatal Folkestone ward. We also visited the community midwifery teams at Kent and Canterbury Hospital and Buckland Hospital.

We spoke with over 30 staff including executive directors, specialist clinicians, service leads, midwives, nurses, maternity support workers, domestic staff, consultants, registrars, junior doctors and student midwives.

We spoke with 16 women, carers and relatives to gain their views and their experience of the service they were receiving.

We looked at a range of policies, procedures, data we had received from the trust and other documents relating to the running of the service.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. Our inspection focused on all 5 of our key lines of enquiry (KLOEs) safe, effective, caring, responsive and well-led.

To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led.

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

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