University College London Hospitals NHS Foundation Trust

University College Hospital & Elizabeth Garrett Anderson Wing

Inspection report

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Ratings

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

Our findings

Overall summary of services at University College Hospital & Elizabeth Garrett Anderson Wing

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at University College London Hospitals NHS Foundation Trust

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

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

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

Our ratings of the maternity service stayed the same and the ratings for the hospital remained the same. We rated safe and well-led as good, and the hospital rating remained as requires improvement.

University College London Hospital is a large teaching hospital located in central London. Maternity services are located in the Elizabeth Garret Anderson Wing. The maternity service at University College London Hospital provides consultant-led and midwife-led care for both high and low risk women. The hospital is a tertiary referral centre for complex maternal and fetal indications.

How we carried out the inspection

During our inspection of maternity services at University College London Hospitals NHS Foundation Trust we spoke with 35 staff including senior leaders, obstetric staff, specialist midwives, matrons, midwives, student midwives, maternity support workers, nursery nurses, clinical governance leads and safety champions to better understand what it was like working for the service. We interviewed leaders to gain insight into the trust's leadership model and the governance of the service. We reviewed 6 sets of maternity and 10 medicine records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recent reported incidents as well as audits and audit actions.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 48 feedback forms from women. We analysed the results to identify themes and trends.

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

Maternity

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people, they understood how to protect women and birthing people from abuse, and managed safety well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were working towards a new vision and strategy. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

- The service did not always control infection risk well. During our inspection not all staff followed infection control principles because they were not adhering to the trust's uniform policy. Leaders also recognised this and have put actions in place to improve performance.
- Staff carried out checks on emergency equipment. Following the inspection, the service audited their equipment. This involved carrying out further checks and supported the trust wide Pateint Emergency Response and Resusitation Team, to educate on the importance and quality of checks.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff had completed this to meet the trust target.

The Maternity specific mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included a full day on fetal wellbeing, cardiotocograph (CTG) and Intermittent Auscultation competency assessment, simulated obstetric emergency training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Inpatient midwifery staff received and kept up-to-date with their mandatory training. The trust had a 85% target for staff completing their trust wide mandatory training and a 90% target for completing maternity specific training. Inpatient

midwifery staff were meeting the trust target. For example, 100% of staff who supported women and birthing people when using a birthing pool were compliant with pool evacuation training. This training was supported by discussions in team huddles to promote competence. Training videos for pool evacuation had been created by the education team, who also facilitated live multidisciplinary drills. Inpatient midwives were 93% compliant with Cardiotocography (CTG) training, 93% compliant with medicine management and medicine competency testing, 90% compliant with neonatal life support (NLS). Adult life support (ALS) training fell under the trust wide target of 85%, and 86% of midwifery staff were compliant with eLearning for advanced life support (ALS) training and 93% compliance with ALS classroom training. The trust reintroduced ALS into the maternity mandatory multi-professional obstetric simulation training to increase compliance with a forecast of being 90% or more compliant by September 2023.

Staf told us they received a week of protected time off site in the education centre for face to face training, but that it was difficult to find time to do their eLearning modules.

Medical staff received mandatory training but were not meeting the trusts target of 85%. For ALS obstetricians were 63% compliant. For all other mandatory training modules obstetricians were 71% compliant. The trust had recognised their medical staff were below target and had made changes since April 2023, combining ALS within the Multi-Professional Maternity Specific training day. We were told that recent industrial action had affected multi-professional maternity specific training compliance. Following the inspection, the trust informed us there had been study days in June, July and August helping to improve compliance. The trust had a forecast that more than 90% of all staff groups would be compliant by September 2023.

The service made sure, and staff told us that they received multi-professional simulated obstetric emergency training the compliance rate for the last 18 months was 100% for inpatient midwifery staff and 80% for obstetricians, with 90% forecast for September 23. The service provided evidence of over 90% of all staff groups attending multi-professional simulated obstetric emergency training for the year 4 maternity incentive scheme.

Safeguarding

Staff understood how to protect women and birthing people 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.

The service had a named midwife for safeguarding as well as a specialist safeguarding midwife with support from the safeguarding lead for children and young people as well as from the trust's wider safeguarding team.

The safeguarding team ran antenatal clinics supporting women and birthing people with additional social needs such as those experiencing homelessness, young people under 16 years old, drug and alcohol misuse, families supported by social services, as well as women and birthing people who need support with learning difficulties. We observed the safeguarding team attending staff handovers to ask if there were any women or birthing people with safeguarding needs and to offer support to staff.

Staff received training specific for their role on how to recognise and report safeguarding concerns. Training records showed which staff had completed Level 3 safeguarding children as set out in the trust's policy and in an intercollegiate guideline (2019). Midwifery staff were 93% compliant with safeguarding training. However, obstetricians were below the trust target of 85% with 71% of staff being compliant.

Maternity

Midwives in addition to 3 yearly training receive annual updates regarding, perinatal mental health, domestic violence, female genital mutilation and a children's safeguarding update. Following the inspection, the trust informed of additional safeguarding training days, which had increased the compliance rate for obstetricians. The trust forecast they would have compliance rates above 85% by the end of October 2023.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics. For example, staff told us that they would arrange a tour of the unit for women and birthing people who had neuro diverse conditions to ensure they were familiar with the unit. They also organised a side room with dimmed lighting where needed.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse. An audit showed staff had documented responses to the domestic abuse question in 87% of notes in the last 6 months. Additionally, staff would also ask women and birthing people about female genital mutation. The audit showed that 98% of women and birthing people were asked this question.

Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team. Women and birthing people with safeguarding concerns were discussed sensitively during handovers and staff safety huddles.

Staff worked closely with partner organisation, such as GP surgeries to ensure they received all relevant information, ensuring they were keeping women and birthing people safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding team supported staff when making referrals to the local authority. Staff explained safeguarding procedures, how to make referrals and how to access advice. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the trust's baby abduction policy and baby tracking policy, undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The trust told us there had been 2 baby abduction drills in the last 6 months.

Cleanliness, infection control and hygiene

The service managed infection risk reasonably well. They kept equipment and the premises visibly clean and had good compliance with hand hygiene practices. However, staff did not always adhere to the trust uniform policy and some infection control measures. This put women and birthing people, themselves, and others at risk from infection.

Maternity

We observed that not all staff followed infection control principles and were not adhering to the trust's uniform policy. This had also been recognised by leaders during our inspection. Immediately after the inspection, leaders cascaded information to staff discussing the importance of infection prevention control (IPC) and why the uniform policy supports effective IPC measures. Leaders discussed the issue during every handover, and emails were sent to all staff, discussions were had at the midwifery forum, senior midwife team meeting and at the board safety champion forum.

The service monitored and audited staff's compliance around hand hygiene. The hand hygiene audit in April 2023, which covered all areas of the service showed 95% or above compliance. Due to the non-compliance with uniform policy observed during the inspection, the service had enforced daily checks. Leaders told us the manager of the day would continue to do this until the service was 100% compliant.

Maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. Wards were refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. Data received showed the service audited their clinical areas for cleanliness monthly. Action was taken when needed following the audit. For example, reporting to housekeeping team when dust had been missed in hard to reach areas and informing estates of leaking taps.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. Staff used 'I am clean stickers' to identify areas that had been cleaned.

We observed the service to be visibly clean. Staff told us that the electronic records system they use enabled them to inform the housekeeping staff when a room needed to be cleaned. We were told this system was effective and saved time.

Staff assessed and recognised when women and birthing people needed to be barrier nursed to prevent the spread of contagious diseases. We observed this practice to be in place during the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had ample facilities and equipment to meet the needs of women and birthing people's families. Departments within maternity services were secure.

There were adult resuscitation trolleys in each clinical area, so all staff had easy access in an emergency. All clinical areas had an emergency trolley for obstetric emergencies. We checked the emergency trolley in labour ward, Maternal and Fetal Assessment Unit, postnatal ward and the antenatal ward. There was evidence that daily checks had been completed. However, during the inspection we found several consumable items that were past their expiry date in adult resuscitation trolleys across the service. This was raised with staff and the leaders during the inspection. Action was taken immediately. The service has carried a subsequent review of the contents of all adult resuscitation trolleys, reviewing and removing over stocked items, and ensuring standardisation across all wards. The service liaised with the trust wide patient emergency rapid response team (PERRT) who were carrying out additional spot checks of adult

resuscitation trolleys across the service. The PERRT and senior leaders had circulated updated educational resources in the form of a picture checklist to support staff when carrying out checks of the equipment. As well as videos of daily, weekly, and monthly checks. Leaders told us these videos have been shared within the maternity services as well as the wider women's health division.

Women and birthing people were assessed and triaged in the Maternal and Fetal Assessment Unit (MFAU). MFAU was open 24 hours a day providing a telephone and face to face triage service to women from 14 weeks of pregnancy up to 6 weeks postnatal. Women and birthing people attended MFAU for an initial midwifery or obstetric review with signs of labour, or any problems related to pregnancy or following birth, for example, experience of reduced fetal movements, bleeding in pregnancy or abdominal pain.

There were portable ultrasound scanners, cardiotocograph (CTG)machines and observation monitoring equipment. In addition to emergency attendances, there was a scheduled appointment list for women and birthing people requiring non routine blood tests and investigations and obstetric review, such as blood pressure profiles and iron infusions in an outpatient setting. These clinics were staffed by additional staff so as not to impact on staffing in the MFAU.

The MFAU had 7 rooms, a reception area and waiting room for women and birthing people. One room was used for the initial assessment, 2 rooms accommodated 2 couches and were used for women and birthing people who were having non-invasive assessments, screens were used if there were 2 women in these rooms. There were 2 additional rooms dedicated for scanning and assessments.

Labour ward had a 4 bedded closed observation bay, for women and birthing people who required high dependency care and 13 birthing rooms. One room included a pool for labour and birth. All rooms had ensuite facilities and facilities for women and birthing people to aid labour. For example, birth balls, and birthing stools. The service had enough suitable equipment to safely care for women, birthing people and babies.

There was a dedicated bereavement room. Women, birthing people, and families were able to access the bereavement room via a separate entrance from the main labour ward. All labour rooms were sound proofed, which allowed other rooms to also be used as bereavement rooms if needed. We were provided with estates plans for a newly located and renovated bereavement room, which has been designed to be more comfortable for women, birthing people and their support person and focus on the aesthetic of the environment to make this appear less clinical. Following the inspection, we were informed that work would be commencing in August 2023 and that facility is expected to be completed in December 2023.

Women and birthing people who had a planned caesarean birth would be prepared for this on the labour ward prior to going to the obstetric theatre.

The service had 2 theatres, for elective (planned) and emergency caesarean sections. The service ran an elective list every weekday with regular additional lists on weekends.

Afternoon theatre lists were available for women and birthing people staying in the private ward known as The Fitzovia Suite.

The Birth centre had 5 rooms. All rooms had ensuite shower facilities, reclining chair beds, birth stools, as well as bean bags and birth balls. Two rooms have birthing pools. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. Pool evacuation nets were available in all pool rooms.

Maternity

The service was a tertiary referral centre for complex maternal and fetal indications. There was an established Fetal medicine department who supported women and birthing people when abnormalities were identified during routine appointments as well as taking referrals from the local area and across the country. Leaders told us they had secured funds for calming sky lights to be fitted in rooms where complex screening techniques were performed to support women and birthing people during these anxious times. Women and birthing people who needed to stay overnight due to the procedure performed in the fetal medicine department were accommodated on the antenatal ward.

The service had additional interventional services for babies identified during pregnancy, as having serious abnormalities requiring fetoscopic laser surgery for twin-to-twin transfusion syndrome, and FETO for congenital diaphragmatic hernia. The trust is the only UK commissioned centre offering in-utero fetal surgery for spina bifida.

Additional clinics for infectious diseases also took place, supported by a specialist midwife.

The design of the environment followed national guidance. However, staff told us that they felt more storage space was needed. Doctors that we spoke with said they did not have any designated space, making finding space to privately discuss patient care or to take a break difficult.

The maternity unit was fully secure with a monitored entry and exit system.

The birth partners of women and birthing people were supported to attend the birth and provide support.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Assessing and responding to risk

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

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 6 MEOWS records and found staff correctly completed them and staff had escalated concerns to senior staff. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating.

The service completed snapshot monthly audits to review the use of MEOWS. Audits showed compliance during intrapartum period improving from April 2023 onwards. For example, compliance rates were 50% in February 2023, 40% in March 2023, 80% in April 2023 and 70% in May 2023. Audits had led to an action plan, which stated using MEOWS and escalation to be included in the mandatory training, ongoing sharing of learning in “Big 4 safety messages” and the management of MEOWs scores and escalation discussed during handovers and safety huddles. The service also audited the use of MEOWS postnatally with compliance being 90% in February 2023 and 100% in March, April, and May 2023. MEOWS has been built electronically within the local electronic notes system to support recognition of the deteriorating patient, and the trust is engaging with the national MEOWS 2 rollout.

Maternity

Women and birthing people who presented to the MFAU all had a risk assessment on arrival. This triage approach is based on a recognised, standardised risk assessment tool and pathway. This initial assessment would determine a categorisation of red, orange, yellow, or green, which guided which women and birthing people required ongoing care immediately, their prioritisation and who needed to be seen by a second midwife or a doctor or if they could be discharged home.

The triage audit data from March 2023 to May 2023 showed an improvement in meeting the recommendation for completing the initial assessment within 15 minutes of attending MFAU. In March 45% of women and birthing people were seen within the 15 minutes time frame, in April 2023 60% of women and birthing people were seen within the time frame and in May 2023, 85% of women and birthing people were seen within the time frame. 90% of women were all seen within 30 minutes of arrival.

Following the audit, the service put in place refresher training for staff working in MFAU, expanded the training to the wider midwifery and obstetrics team, continued to audit the use of the assessment tool and the impact of the training packages. They also held meetings for the senior midwifery team to understand factors affecting the assessment tool such as staffing and acuity.

When women and birthing people attended MFAU with reduced fetal movements the service had doctors and midwives who were trained in scanning, with scanning equipment available. This meant women and birthing people were assessed without delay and care plans put in place where risks were identified.

Staff knew about and dealt with any specific risk issues. Women and birthing people had a clinical, wellbeing and social risk assessment completed at the booking appointment and at each antenatal contact. There were specialist antenatal clinics to support women and birthing people who had been identified as being at high risk during their pregnancy.

The maternity service guidance is to offer universal screening to all women for gestational diabetes, as opposed to national guidance where screening was targeted to women and birthing people with risk factors for developing gestational diabetes for example age, body mass index (BMI), family history or ethnicity. This approach enabled early diagnosis of gestational diabetes, specialist input and support.

When staff identified the need for further screening tests, the service was able to provide all women with onsite same day first trimester screening. This enabled women and birthing people to have their results and face to face counselling on the same day, and more time to explore next steps and have input from fetal medicine specialists when abnormalities had been found.

Staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited by doing a snapshot documentation audit performed to review the standard of completing fresh eyes hourly Compliance of fresh eyes being documented hourly in the last 6 months varied. For example, it was 92% in January 2023 and 54% in March 2023. Reasons given for poor compliance was a combination of CTG and intermittent auscultation (IA) being used prior to being transferred to the labour ward and second midwife not being available. More recently in May 2023 the service had documented fresh eyes in 73% of notes audited. A yearly fetal monitoring deep dive audit contributed to the divisional educational audit day and was led by the fetal monitoring midwife. The documentation audit had an action plan stating the findings were to be shared with the fetal monitoring midwife to support development of quality improvement project to improve compliance. We reviewed 4 CTG records and found fresh eyes had been completed for all cases.

Maternity

The service recognised the importance of completing venous thromboembolism (VTE) assessments. Audits showed compliance of 95% in April 2023 and 70% in May 2023.

The service had 24-hour access to mental health liaison and specialist mental health support. The trust recognised the need for additional support for women and birthing people who had additional mental health needs. They have a consultant psychologist and a perinatal mental health specialist midwife within the maternity service. This specialist team could support women and birthing people antenatally as well as offering guidance to staff when they were unsure how to support women and birthing people with complex mental health needs. They said that they did not have to wait for mental health input and would not hesitate to make referrals when support was needed. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Consultant midwifes also supported women and birthing people who have anxiety due to traumatic past experiences with previous pregnancies and births. They ran a clinic for fear of birth, supporting women and birthing people to understand their options and to plan individualised care.

Women and birthing people chose to give birth at University College Hospital London even if they did not live locally. Staff told us they had conversations with women and birthing people about how they would plan to get to the hospital. They asked women and birthing people to consider the risks of travelling large distances and told them not to pass other maternity departments in an emergency.

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

We observed that shift changes and handovers included all necessary key information to keep women and birthing people and babies safe, including the need for an interpreter to be requested. Staff held 2 safety huddles per shift to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. Leaders audited the use of SBAR during handover between March 2023 and May 2023; these audits showed there was 90% compliance with SBAR during handovers. To make improvements the service had an action plan in place to reinforce learning.

Staff completed newborn risk assessments after delivery, using recognised tools and reviewed this regularly. The service audited the use of the risk assessment between March 2023 and May 2023 they achieved 96% of assessments completed within 72 hours of birth. Delays documented were related to maternal request, transfer out and workload in the unit.

The service provided transitional care for babies who required additional care and observations, to enable mother and baby to be cared for together. The transitional care service was located on the postnatal ward. The transitional care team included neonatal nurses, midwives and nursery nurses and there was a close working relationship with the neonatal medical team.

Maternity staff completed a postnatal risk assessment prior to discharging women and birthing people into the community, and ensured appropriate information was securely shared with other maternity providers, GPs and health care providers as needed.

Maternity

The service had unit wide safer staffing and safety huddles to assess the needs of women and birthing people receiving maternity care as an inpatient, and as well as looking at the needs of women, birthing people and babies that had the potential to need to be transferred to the unit. They worked with other local maternity services in the area and shared information regarding neonatal cot availability for babies that had been identified as requiring additional care.

Women and birthing people who chose to give birth outside of guidelines were supported. These women were offered an appointment with the consultant midwife and/or an appointment with a consultant obstetrician. The consultant midwife discussed the woman's or birthing person's decision, and they agreed a birth plan together. The aim was to support women and birthing people's choice and to ensure the birth was as safe as possible. The consultant midwife and on-call team were available to support midwives caring for women outside of guidance. Midwives told us the teams worked together well to support informed choice. Midwives also felt well informed and well supported in these situations.

The service had recognised their local population of women and birthing people included international refugees who were housed in local hotels by the Home Office. The service acted promptly and provided antenatal clinics for these women and birthing people in the hotels and ensured the use of interpreting services to enable the women and birthing people to understand and communicate with the midwives and obstetricians.

Midwifery Staffing

Midwifery staff had the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. 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.

The service had the required number of midwives funded by the trust, as recommended by an external workforce review and report. The data shared from April 2023 showed 11 whole time equivalent vacancies for band 5 and 6 midwives, which was less than 5%, and below the target of 8% set by the trust. The substantive midwifery vacancy gap was filled with bank midwives, who were familiar with the service. Midwifery vacancies had reduced significantly as a result of focused recruitment and retention processes. More staff had joined the service than left in the last 5 months, with 9 newly qualified midwives in the pipeline due to join the service once they had completed their training

During April 2023, the trust reported intermittent, temporary closure within the Elizabeth Garrett Anderson site due to short term sickness impacting on staffing. The service worked closely with local maternity units to ensure women and birthing people were safe during this time.

Managers regularly reviewed staffing in all areas of the service, using red, amber, green rated situation reports to monitor target number of staff against actual numbers and planned accordingly. Bank staff who were familiar with the service often working regular shifts to cover gaps in the midwifery rota.

The service had six continuity of carer teams, one team worked in a caseload 'on call' model of care and five teams provided a hybrid model, where midwives provided cover pregnancy and postnatal care in the community and also contributed to the birth centre rota. The case load teams were geographically based and had a mixed caseload. The service regularly reviewed the model of midwifery care provided, alongside the staffing in the inpatient and outpatient areas, and vacancy to ensure safe staffing across all areas of the service.

Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. As well as reporting events covered as red flags in line with NICE guidelines the service also reported on staffing issues relating to the triage phone line being covered as amber status as well as red status. Data the service shared for December 2022 until May 2023 showed there were 351 flags reported. However, there were no occasions where the service categorised these flags to be red status. There were 43 occasions where the staffing had led to an amber status during the 6-month period. The highest reported staffing issue led to delays in induction of labour (IOL). During December 2022 there were 26 occasions where women and birthing people were affected by delays in the induction of labour process. Leaders told us that there was now an induction of labour working group, reviewing IOL guidelines. We were told when the acuity of the service was high, there were delays in IOL. The data showed that improvements had been made, resulting in only 7 delays in IOLs in April 2023 and 16 in May 2023.

There was a supernumerary labour ward shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. There had been 3 occasions in the last 6 months where the labour ward co-ordinator had not able to be supernumerary due to the needs of the women and birthing people on the unit.

The ward manager had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas. In addition to the supernumerary labour ward co-ordinators the service also had site managers who were supernumerary. Site managers had a helicopter view of staffing and were able to support clinical areas by reallocating staff to the area of highest need.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. There had been no agency staff used at the service in the last 12 months.

Newly Qualified Midwives who joined the trust were supported to undertake a bespoke preceptorship programme based on the Capital Midwife recommendations. They were allocated a mentor in each clinical area and supported by the Clinical Practice Facilitators.

The service supported learning placements for student midwives from three higher educational institutes Students we spoke with said they felt supported and that the service had an open learning culture.

Staff were trained to support women and birthing people who required enhanced care. This meant women and birthing people were looked after within the department, in the recovery room and did not need to be moved to an intensive care unit allowing them where possible to stay with or near to their babies.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. A team of Clinical Practice facilitators supported midwives with education and training, and clinical skills support. Data we received relating to appraisals was broken down by staff bands Band. Compliance rates were band 8 staff 92%, band 7 91%, band 6 94%, Band 4 (Infant feeding team, and nursery nurses) 100%, Band 3 83%, Band 2 96%.

Managers made sure staff received any specialist training for their role. For example, the service was working towards increasing the number of midwives who were trained in enhanced care, midwives who worked in the specialist clinics such as fetal medicine and diabetes clinics received additional training. There were also midwives and doctors undertaking a master's degree in sonography.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. At the time of the inspection all medical vacancies were appointed to with no current vacancies

In the last 6 months the service had used locum cover for 180 shifts to cover sickness. The majority of these shifts were covered by internal medical staff currently working in the service. On 32 occasions, shifts were covered by former employees. This meant the medical staff were covering shifts were fully inducted and familiar with the service.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service had collaborated with University College London to provide a master's degree in Obstetric Ultrasound and this programme supported doctors and midwives to build skills and develop in their career.

The service supported trainee doctors to train as obstetric specialists and held special interest training with training opportunities for medics of all grades.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Junior and middle grade doctors we spoke with said that they felt supported by senior doctors, that there were great opportunities for learning and development. They knew when to escalate to a doctor of seniority and felt there was a culture of being supported when they did escalate. They told us they had good working relationships with midwives and other professionals such as anaesthetists.

The service had consultant covering on the labour ward from 8am till 10pm every weekday and from 8am until 9.30 pm on weekends. Out of hours there was a consultant on-call system in use. Accommodation was available on site for consultants on call who lived more than 30 minutes away from the hospital.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The service used the trust wide electronic record keeping system. We reviewed 6 records and found they were clear and complete. The service audited care records monthly to ensure the quality of their records.

Maternity

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

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

The service had a digital midwife who was able to support staff when needed with any issues relating to the electronic records system.

Women and birthing people accessed their own electronic records using a portal. If a woman or birthing person did not have access to an electronic device or if English was not their first language, notes would be printed off for them. The trust and other local maternity services were using the same electronic system. This meant if women and birthing people were to need care in a different local hospital, the staff would still be able to access their records. Additionally, if women and birthing people needed care in a different location within the hospital such as Emergency Department, all staff would still be able to access their maternity records.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

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

Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature.

Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation. Since our last inspection in December 2018, improvements had been made to the way in which staff monitored the temperature of storage facilities for medication. Staff acted when temperatures were not in range escalating concerns to estates.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on a digital system for the10 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Maternity

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

The Perinatal Mortality Review Tool (PMRT) was embedded throughout the service. Staff told us PMRT was a multidisciplinary team responsibility and external staff with expertise were involved in all PMRT reviews. Learning identified is shared back to the division through governance meetings and newsletters, with monitoring of completed action plans maintained by the governance team. Women and birthing people were involved in PMRT reviews and had a named point of contact, so they had continuity and support throughout the process. The Perinatal Mortality

Mothers and babies reducing risk through audits and confidential enquires (MBRRACE) results from the 2021 report had been discussed at the board safety champion and maternity and neonatal leadership meeting in May 2023. The report showed stillbirth rates were 4.45 per 1,000 births, which is more than 5% higher than the average or similar trust. This led to the trust completing a deep dive into all stillbirths within the service and reviewing the PMRT to identify any learning actions. Examples of learning actions were electronic record recording system to alert staff to high blood pressure, urgent implementation of computerised cardiotocography (CTG), and raise awareness of language support services. Action plans to implement learning from the reviews were identified and have been completed. Plans were also in place to recruit a PMRT lead midwife who was due to be in post by June 2023.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers and the clinical governance team were aware of the criteria for reporting incidents to the Healthcare Safety Investigation Branch (HSIB) for investigation and have a clear process for a rapid review by the multidisciplinary Clinical Incident Review Group (CIRG) for any still birth or neonatal death requiring a 72-hour review. The trust had referred 2 incidents to HSIB in the last 6 months. During the same 6-month period the trust had received 3 final reports back from HSIB. In total there were 5 safety recommendations made in the reports and the trust shared action plans and learning with local maternity services.

Recommendations from HSIB reports included ensuring that the induction of labour process was individualised and discussed with mothers, to support staff to challenge and escalate to senior staff when there were differing clinical opinions around CTG. Actions in progress were for a review of the induction of labour guidance and implementation of Royal College of Obstetricians and Gynaecologists (RCOG) escalation tool kit.

The service had 89 incidents that had been open over 60 days. These incidents had been graded with 61 being no harm caused, 15 low harm caused, and 13 moderate harm caused. None of the open incidents had been graded as severe harm caused.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations. Staff involved women and birthing people and their families in the investigations, managers shared duty of candour and draft reports with the families for comment. Those involved in incident review processes considered the potential impact of health inequalities on the outcome being reviewed.

Managers shared learning with their staff about never events that happened elsewhere. The service had a weekly newsletter where they share 3 or 4 key messages, learning from events in other trusts was shared at board and safety board meetings. The women's health safety team's bimonthly newsletter contained learning from incidents. The service also carried out staff debriefs following incidents with opportunities for immediate support and learning and signposting to the in-house staff psychological and wellbeing services. Student midwifes told us they were able to attend these separately for their own learning.

Maternity

Staff reported serious incidents clearly and in line with trust policy. Staff were able to tell us about the process for reporting incidents, they said that they were supported when incidents were investigated and that incidents were thoroughly investigated.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

There was evidence that changes had been made following feedback. The perinatal mental health midwife told us of training she had delivered following an incident where a woman had needed additional support due to her social needs. This training had led to better awareness of additional support care plans.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There was a clearly defined management and leadership structure in place. The maternity service was led by a director of midwifery (DOM), divisional manager, divisional clinical director, and clinical obstetric leads. The leadership team were supported by a deputy director of midwifery, 2 consultant midwives, 2 Band clinical matrons, matron for governance and safety, a deputy matron. In addition to 4 leads covering Governance, safeguarding, education and research, and 16 specialist midwives.

The service was supported by a board maternity safety champion and a non-executive director. The trust medical director was one of the board maternity safety champions. They encourage staff to speak up and arranged for staff to speak openly and directly to the board at a public board meeting. This enabled their voices to be heard and for the impact of their work to be listened to at board level.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. We observed the clinical lead interacting with staff of all levels, they knew everyone by name. The DOM had started at the service in October 2022. Staff told us they were approachable, listened to staff and acted when they had concerns.

Maternity

Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports, the East Kent report (Kirkup, 2023) and The three-year delivery plan Maternity and Neonatal services (March 2023) and planned to revise the vision and strategy to reflect these recommendations.

The trust published a new strategy in May 2023. This led the maternity leadership team to review the maternity strategy. Plans were for the new strategy to align with the trust strategy whilst including a maternity specific vision for staff to feel invested in with clear objectives.

Band 7 staff attended development days in April and May 2023 where they were asked to start thinking about a vision, with objectives that meant something to them. Part of the new maternity vision included, reducing health inequalities & inequities to improve health outcomes and experiences for families. Further development days were planned to include all staff groups. The service was looking to have their new strategy finalised by the beginning of September 2023.

The current vision and strategy and plan for the new strategy, were focused on sustainability of services and aligned to local plans within the wider health economy.

Culture

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

Most staff we spoke with said they felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Leaders were confident that staff would talk to them about difficult issues as there was an open culture at the service.

Most staff we spoke with said that they had not experienced any bullying or harassment whilst working at the service. Some staff said that they had but that this had been a few years ago and that the culture at the service had changed. We were also told that when staff had been spoken to in an unprofessional manner by colleagues that other staff had stepped in, reported issues and challenged others if they were behaving inappropriately.

Maternity

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

Staff told us that there was a psychologist available for staff should they need additional support. We were told that managers recognised when staff were struggling with stress, managers discussed referrals and support available for staff.

We observed staff being encouraged to attend cultural safety days, training days away from the service, where cultural safety and equality and diversity issues would be discussed.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care. For example, staff who supported women and birthing people with gestational diabetes had received training in supporting people from all cultures with their dietary needs, they did this in a compassionate manner, listening to the needs of the women and birthing people.

Staff understood and respected women and birthing people's cultures, they were aware of the range of backgrounds of people supported at the service and made sure appropriate religious materials and foods were readily available. Staff who worked in the specialist diabetes clinic spoke about how if a woman or birthing person was struggling with religious aspects of their diet, they would encourage them to talk to their religious leaders for support.

Staff made sure to utilise interpreting services for women and birthing people where English was not their first language. Staff used face to face interpreters, language line and an ipad on wheels as well as on occasions asking internationally born staff if they could interpret.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board, and from the board back to the ward.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Most policies were up to date. Where policies were not up to date leaders had assessed the policies to still be safe so could still be followed. For example, the escalation policy had been due to be reviewed in August 2022, but had been assessed as being appropriate for use and would be ratified to incorporate the Pan London escalation guideline and Operational Pressures Escalation Levels Framework (OPEL Framework)

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. However, action plans were not specific in how improvements were going to be achieved. For example, CGT audit showed fluctuations in compliance with the worst month being March 2023. The action plan stated the audit would be shared with the fetal monitoring midwife to support development of quality improvement project, with a completion date for this action being December 2023. This did not show how the compliance would be improved and what action was to be taken. Following the inspection, the trust shared with us how their small snapshot audits contributed to the wider action plans in relation to themes and trends. They had completed a recent project triangulating data from claims, incidents and complaints and a robust action plan focusing on improving fetal wellbeing. This included actions around fresh eyes.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Maternity

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

The service worked with MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) to ensure they reported any maternal deaths. We saw the service reviewed all the information and this was shared with the board, seniors, and staff to reflect on learning.

The service had a risk register in place. We reviewed the risk register and saw the service had recorded any incidents rated as high or extreme risks. Against these was the mitigation actions and actions to address the risk. The register stated clear ownership of the risk, timescales for review or completion.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service achieved all 10 maternity safety actions for year 4 of the scheme, and there was evidence of progress against the safety actions taken to the board. This is evidenced in the public board papers in November 2022 and January 2023.

The service was compliant with all 5 elements of the saving babies lives care bundle.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was reviewed monthly by managers and the senior clinical team together using internal benchmarking and comparisons across the Local Maternity and Neonatal System (LMNS) and London. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service used an electronic recording system which was password protected for each staff member, this ensured they were secure**.**

Data or notifications were consistently submitted to external organisations as required.

The service was working with “One London” in order to work towards maternity systems being accessible to all local services. One London was created in 2018 supported by NHS England and the Greater London Authority to transform services by joining up information to support fast, safe, effective care, in conjunction with London’s 5 integrated care systems.

Maternity

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Following the MVP 15 steps in April 2023, where the MVP chair and a small team of service users walked around the service there were several recommendations made, including the need for the translation services to be advertised. On the day of the inspection a banner was visible giving women and birthing people information about interpreting services.

We reviewed the minutes of the most recent meeting. We saw a range of topics were discussed. There was a positive relationship between the service and the MVP. The service was positive about their relationship with the MVP and valued their support and input with improvement work.

The service had several staff newsletters where they feedback on safety issues and incidents. There was a weekly Elizabeth Garret Anderson Wing newsletter, a weekly junior doctors newsletter covering issues such as training, timetables, new starters, and study of the week. As well as a women's health newsletter where there was positive feedback from patients as well as findings from incidents and investigations.

Leaders understood the needs of the local population as well as the wider population who used the service.

The service collected data on ethnicity including analysing data around ethnicity following incidents in order to learn from the incidents.

Learning, continuous improvement and innovation

All staff were committed to continuous learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

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

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Staff discussions during handover included "The big 5" where they would discuss learning from any recent safety issues.

An example of quality improvement was a project undertaken following feedback from women and birthing people of poor experiences when being discharged and waiting for medicines 'to take out' (TTO's) . Doctors and pharmacists had worked together to agree better ways of working, leading to less delays in discharging women and birthing people home with their babies.

Quality improvement was a regular item on the agenda of the maternity governance meetings.

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Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

The service was part of the Capital Midwife Ethnic Minority Midwives Fellowship, an initiative launched in London in 2021 designed to support band 6 and 7 midwives from ethnic minority groups to develop and move into leadership roles. Senior midwives encouraged other midwives to join the programme and were observed talking about the benefits during staff handover.

Outstanding practice

We found the following outstanding practice:

- The service had collaborated with University College London to provide a master's degree in Obstetric Ultrasound and this programme supported doctors and midwives to develop in their career. This programme had significantly increased the availability of obstetric sonographers in the service.
- All pregnant women and birthing people were screened for gestational diabetes rather than just focusing on high-risk categories. This meant early diagnosis and support to women and birthing people in a low-risk category rather than waiting for women and birthing people to develop symptoms.
- The service had their own laboratories which meant complex screening tests results were able to be received quickly reassuring women, birthing people and their families and any concerns were responded to in a timely manner.
- The service considered the needs of the women and birthing people who had chosen to use their service and adapted clinics to support, for example the consultant midwives ran a clinic supporting women and birthing people suffering with anxiety around the fear of birthing. This could have been due to past traumatic births.
- The service promoted a positive culture where they worked towards identifying and reducing health inequalities. They did this through staff training as well as additional clinics, where women and birthing people were supported by being given information that was culturally relevant to them as individuals.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust 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.

University Collage Hospital London Elizabeth Garret Anderson Wing

Action the trust SHOULD take to improve:

- The service should continue to ensure all staff complete mandatory training, including advance life support and safeguarding adults and children's training in line with the trust's own targets.
- The service should continue to audit compliance and implement associated actions in relation to the 'fresh eyes' intervention when reviewing fetal wellbeing in labour, to improve overall compliance and reduce risks to women and birthing people.
- The service should ensure that all staff adhere to the uniform policy to maintain effective infection prevention control.

Maternity

- The service should ensure that daily checks are completed, recorded and are effective for all emergency trollies.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors. There were 2 specialist advisors and was observed by the deputy chief executive. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.