HCA International Limited

# The Portland Hospital for Women and Children

## Inspection report

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Date of inspection visit: 21 March 2022 and 22 March 2022
Date of publication: 26/05/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, 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 patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However:

- We found that domestic abuse question checks on admission were not documented well.
- Equipment checks for high dependency room on the labour ward were not done regularly.
- On the day of inspection, some medicines including emergency medicines were stored incorrectly and did not match the daily stock list or were kept in an unlocked fridge. The service rectified this immediately on the same day.
- There was variable knowledge of incidents that occurred across the service, with not all staff able to articulate any learning from these.
- At the time of inspection, compliance was lower than expected for some nursing staff competencies in the paediatric intensive care unit (PICU), particularly intravenous infusion training (76%) and drugs by direct injection (83%). Senior staff told us this was due to higher levels of sickness absence due to COVID-19. The hospital ensured fully competent staff were on shift at all times. Figures provided for May 2022 showed that compliance levels for these two competencies had improved to 100% and 97%, respectively.
- At the time of inspection, the inspection team identified concerns about the staffing levels of the on-site security team. Senior staff assured us that they mitigated security risks through a range of measures and that additional support could be offered by the front of house and portering team, but they would review security staffing levels and ensure these were appropriate.
- Staff we spoke to whilst on inspection told us equipment shortages and delays in fixing or collecting broken equipment occurred. This meant there was some clutter in areas of the hospital.
- A mix of paper-based and electronic notes were used across the hospital. Locum RMOs and agency nursing staff could not access the electronic notes, which could cause some fragmentation in regard to record keeping. Some staff on inspection told us issues with the Wi-Fi sometimes meant there were issues with accessing the electronic system at times.

# Summary of findings

- At the time of inspection, only the imaging department and some ward areas were adapted to meet the needs of children. However, the anaesthetic and recovery areas in the imaging department were not child friendly, along with the day case ward and theatre environment. Senior staff told us this was due to the planned refurbishment of the hospital and these areas would be redesigned with children in mind, but this was not the case at the time of our inspection. In addition, there were not many facilities available for older children, especially in the day case ward, where older TVs did not allow them to use streaming services.
- Although end of life care was rare in children and young people treated at the hospital, there was no formal policy or procedure in place regarding provision for children at the end of life at the time of our inspection. Senior staff told us they were planning to introduce a paediatric mortality framework later in the year.
- Not all staff were aware of diversity and inclusion initiatives taking place across the service.
- Results from the previous staff survey had shown a decline on most measures. Staff told us feedback from these surveys had led to some improvements in staff facilities, although many of the areas were not large enough to accommodate all staff taking breaks.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Maternity** | Good  | Our rating of this service stayed the same. We rated it as good because:<br>• The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well.<br>• Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.<br>• Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.<br>• The service planned care to meet the needs of women, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.<br>• Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually. |

# Summary of findings

However:

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- Equipment checks for high dependency room on the labour ward were not done regularly.
- On the day of inspection, some medicines including emergency medicines were stored incorrectly and did not match the daily stock list or were kept in an unlocked fridge. The service rectified this immediately on the same day.
- There was variable knowledge of incidents that occurred across the service, with not all staff able to articulate any learning from these.

## Services for children & young people

Good 

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

- The service had enough staff to care for children and young people and keep them safe. Staff understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives and supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service took account of children and young people's individual needs and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

# Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children and young people to plan and manage services and all staff were committed to improving services continually.

However:

- At the time of inspection, compliance was lower than expected for some nursing staff competencies in the paediatric intensive care unit (PICU), particularly intravenous infusion training (76%) and drugs by direct injection (83%). Senior staff told us this was due to higher levels of sickness absence due to COVID-19. The hospital ensured fully competent staff were on shift at all times. Figures provided for May 2022 showed that compliance levels for these two competencies had improved to 100% and 97%, respectively.
- At the time of inspection, the inspection team identified concerns about the staffing levels of the on-site security team. Senior staff assured us that they mitigated security risks through a range of measures and that additional support could be offered by the front of house and portering team, but they would review security staffing levels and ensure these were appropriate.
- Staff we spoke to whilst on inspection told us equipment shortages and delays in fixing or collecting broken equipment occurred. This meant there was some clutter in areas of the hospital.
- A mix of paper-based and electronic notes were used across the hospital. Locum RMOs and agency nursing staff could not access the electronic notes, which could cause some fragmentation in regard to record keeping. Some staff on inspection told us issues with the Wi-Fi sometimes meant there were issues with accessing the electronic system at times.

# Summary of findings

- There was variable knowledge of incidents that occurred across the service, with not all staff able to articulate what incidents had occurred or any learning from these.
- At the time of inspection, only the imaging department and some ward areas were adapted to meet the needs of children. However, the anaesthetic and recovery areas in the imaging department were not child friendly, along with the day case ward and theatre environment. Senior staff told us the planned refurbishment for these areas would include a more child friendly design, but this was not the case at the time of our inspection. In addition, there were not many facilities available for older children, especially in the day case ward, where older TVs did not allow them to use streaming services.
- Although end of life care was rare in children and young people treated at the hospital, there was no formal policy or procedure in place regarding provision for children at the end of life at the time of our inspection. Senior staff told us they were planning to introduce a paediatric mortality framework later in the year.
- Not all staff were aware of diversity and inclusion initiatives taking place across the service.
- Results from the previous staff survey had shown a decline on most measures. Staff told us feedback from these surveys had led to some improvements in staff facilities, although many of the areas were not large enough to accommodate all staff taking breaks.

# Summary of findings

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# Summary of this inspection

## Background to The Portland Hospital for Women and Children

The Portland Hospital for Women and Children is operated by HCA International Ltd. The hospital service opened in 1983 and has been part of HCA healthcare for the past 15 years. The hospital has 82 in-patient beds, including nine bedded paediatric intensive care unit (PICU), five bedded labour ward and four theatres. It is situated in central London, on Great Portland Street, in the West End, with easy access to public transport and main driving routes. Services are provided from four buildings: 205-209 Great Portland Street, 212 Great Portland Street, 234 Great Portland Street and 215 Great Portland Street. There is also a small paediatric outpatient service located within The Shard. The Portland Hospital for Women and Children provides surgery, maternity care, services for children and young people, termination of pregnancy services and outpatients and diagnostic imaging.

The hospital provides service to both UK and international patients with medical insurance, those who are sponsored by their respective embassies, those who self-fund and a very limited number of patients referred through NHS contracts.

The hospital is registered to provide the following

regulated activities:

· Diagnostic and screening procedures

· Family planning

· Maternity and midwifery services

· Termination of pregnancies (over 16 years old)

· Surgical procedures

· Treatment of disease, disorder, or injury

The hospital has been inspected five times previously, with the most recent inspection taking place in November 2016. The 2016 inspection was a comprehensive inspection of surgery, maternity care, services for children and young people, termination of pregnancy services and outpatients and diagnostic imaging. There were no outstanding enforcement actions from previous inspections, but a number of areas were identified for improvement, even though a regulation had not been breached.

On this occasion, we inspected maternity care and services for children and young people, using our focused inspection methodology as whistleblowing concerns were raised with us. The hospital's current registered manager has been in post since 2019.

# Summary of this inspection

## How we carried out this inspection

We inspected this service using our focused inspection methodology. We carried out the unannounced part of the inspection on 21 and 22 March 2022.

During the inspection, we visited all maternity and paediatric inpatient wards including the labour ward, theatres and recovery, paediatric intensive care unit (PICU) and neonatal intensive care unit (NICU), walk-in children's urgent care centre, the outpatient clinics, day case ward as well as the children's diagnostic imaging unit and the nursery. We spoke with 81 staff including registered nurses, matrons, midwives, health care assistants, allied health professionals, nursery nurses, theatre manager, operating department practitioners, clinical nurse specialists, consultants, RMOs, ward clerks, play specialists, cleaners, porters, service leads and senior managers. We spoke with four mothers, four parents and two children and reviewed 22 sets of patient records and prescription charts.

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

## 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 SHOULD take to improve:**

**Services for children and young people:**

- The service should ensure that nursing staff in the paediatric intensive care unit are compliant with all agreed competencies. (Regulation 12: safe care and treatment)
- The service should ensure that equipment shortages and delays are actioned and resolved as swiftly as possible. (Regulation 15: premises and equipment)
- The service should ensure a formal policy is in place for children at the end of life. (Regulation 12: safe care and treatment)
- The service should ensure that staff facilities are improved across the hospital. (Regulation 15: premises and equipment)
- The service should consider how they adapt the environment of the hospital for children until the planned refurbishment takes place.
- The service should consider how they can improve the access to patient records for all staff including locum and agency staff.
- The service should consider reviewing the security team resources for the hospital and whether the planned staffing levels are sufficient.
- The service should consider how to improve knowledge of incidents and learning across all staff in the service.
- The service should consider how to involve staff in diversity and inclusion initiatives taking place across the service.

**Maternity:**

# Summary of this inspection

- The service should ensure that all relevant information related to domestic abuse checks are documented well. (Regulation 13: safeguarding service users from abuse and improper treatment)
- The service should ensure that equipment checks for the high dependency room on the labour ward are done regularly. (Regulation 15: premises and equipment)
- The service should ensure that medicines are kept in locked fridges and emergency medicines are stored correctly with effective checks done by staff. (Regulation 12: safe care and treatment)
- The service should consider how to improve knowledge of incidents and learning across all staff in the service.
- The service should consider how to involve staff in diversity and inclusion initiatives taking place across the service.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Maternity | Good | Good | Good | Good | Good | Good |
| Services for children & young people | Good | Good | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Maternity

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are Maternity safe?

Good

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

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Nursing, midwifery and medical staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of women and staff. For all staff across the service, the compliance rate with mandatory training modules was 93%, against a hospital target of 85%. Staff received training in sepsis management and the compliance rate with sepsis training was 97%. Managers monitored mandatory training and alerted staff when they needed to update their training.

As the majority of medical staff also had NHS contracts, any mandatory training was undertaken in their parent organisation. The hospital asked for a copy of each doctor's annual appraisal and competencies. All resident medical officers (RMOs) received and kept up to date with their mandatory training.

### 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. However, domestic abuse question checks on admission were not documented well.**

Nursing, midwifery and medical staff received training specific for their role on how to recognise and report abuse. At the last inspection, we told the provider to ensure that all midwives and appropriate maternity staff were trained in safeguarding children level three. At this inspection, we found that 85% of staff had completed this. All clinical staff received level three safeguarding training for children and adults. At the time of inspection, 92% of staff had completed adult safeguarding training. Medical staff employed through practising privileges were required to show that they completed adequate training on an annual basis and the hospital kept a record of this.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff showed an understanding of how to identify adults and children at risk of, or suffering, significant harm and were able to give us example of where they have identified a case with

potential domestic violence concerns and how they worked with other agencies to protect them. However, we found that domestic abuse question checks on admission were not documented well. We reviewed nine sets of maternity notes, a follow up question in the admission booklet to check the domestic abuse screening question was asked during the antenatal period was not completed in six of the nine records reviewed.

There were dedicated leads for safeguarding and an individual on shift with a level four safeguarding qualification 24 hours a day, seven days a week. In the 12 months prior to our inspection, the hospital had made one maternity related safeguarding referral.

Entrances to the wards, including lifts, were secured with electronic swipe access via a staff identification badge. Staff followed the baby abduction policy and undertook baby abduction drills. During our inspection, we were informed that the postnatal ward was not using any electronic tagging bracelet for babies as ongoing building work interfered with the signals. Mitigations were in place, with staff being more vigilant and admittance to the wards only limited to one partner, at the time of discharge a staff member would escort parent and baby to the reception and sign them out. Though all staff were aware of this change in practice, staff we spoke with showed variable knowledge of the time since the tagging system was not in use.

### Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The hospital used “I am clean” stickers to indicate when patient equipment had last been cleaned and was ready for use by another patient.

Staff conducted monthly audits of all areas which checked compliance against the hospital’s policy for cleanliness, infection control and environmental maintenance. A range of audits indicated good compliance with infection prevention and control policies and procedures, with appropriate actions taken where any issues or omissions were identified. Between March 2021 and February 2022, the service reported seven cases of puerperal sepsis or other puerperal infections (0.4% of deliveries) including three cases of surgical site infection, no case of MRSA and Clostridium difficile.

### Environment and equipment

**The design, maintenance and use of facilities, premises and most equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, equipment checks for the high dependency room on the labour ward were not done regularly.**

Women could reach call bells and staff responded quickly when called. The design of the environment followed national guidance. All women on inpatient wards were cared for in single en-suite rooms.

An external company maintained and serviced equipment through an annual contract. Staff carried out daily safety checks of most specialist equipment including resuscitaires. However, we found lapses in the twice-daily equipment checks for the high dependency room on the labour ward. For example, in March 2022, twice daily checks of equipment

were completed fully for eight out of the 21 days, either a day or night check only was done for eight days and no checks were completed for five days. Adult resuscitation trolleys were available on the postnatal and the labour wards. A neonatal resuscitation trolley was also available on the labour ward. All resuscitation trolleys were checked and logged daily with a tamper-evident seal.

The service had suitable facilities to meet the needs of women's families. Maternity staff we spoke with knew the pool cleaning and evacuation procedures for women wishing to have water births. The birthing pool was clean and fit for purpose. The service had enough suitable equipment to help them to safely care for women and babies. Cardiotocograph (CTG) machines were available for women who required continuous electronic fetal heart rate monitoring and to record uterine contractions during pregnancy and labour, which allowed early detection of fetal distress. On labour ward the women were linked to equipment with monitors located at a nursing station, which allowed the multidisciplinary team to keep track of women and babies remotely.

There were facilities within the gynaecology ward and a fridge was used where products of conception and those who were stillborn could be placed. We found a clear system in place to keep record of the content and fridge temperature was monitored regularly.

At the last inspection in the delivery suite, cylinders of oxygen and nitrous oxide were stored in an area which did not have appropriate signage on the door. At this inspection, we found that the provider had introduced appropriate signage for medical gases on the door.

Staff disposed of clinical waste safely. The service had arrangements in place for the handling, storage and disposal of domestic and clinical waste and sharps. We saw clinical and non-clinical waste was segregated into colour coded bags and sharp objects were deposited in sharps bins.

### Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff carried out observations using a modified obstetric early warning score (MOEWS). We reviewed nine MOEWS charts on postnatal ward; staff were completing them fully and accurately calculating the scores and were escalating appropriately when the tool indicated concern about a woman's wellbeing.

Staff completed risk assessments for each woman on admission or arrival using a recognised tool and reviewed this regularly, including after any incident. There was a complex care obstetrics care pathway and referral to the complex care team were made if any risk factors were detected. In addition. All complex cases were reviewed weekly, with any actions or plans being monitored and adjusted. This was uploaded electronically to ensure timely and appropriate access for all staff involved in the woman's care. Women risk assessed as low risk were given the option of giving birth in the midwifery-led birth centre or within their own home.

There was a buddy system (fresh eyes) for review of CTG interpretation, with guidance for escalation where needed. Fresh eyes involved a second midwife checking a CTG recording of a baby's heart rate to ensure it had been interpreted correctly and if necessary to take appropriate action. This was in line with national recommendations. The service used

an electronic fetal central monitoring system on the labour ward. Staff knew about and dealt with any specific risk issues. Staff completed venous thromboembolism (VTE) risk assessments which were used to determine a patient's risk of developing a blood clot, in line with national recommendations. All records we reviewed had VTE risk assessment completed.

Vaginal birth after a caesarean (VBAC) was offered to all women unless there was a medical condition including tocophobia (fear of birth) to ensure patient safety. Women were advised of the services they could contact if they had any concerns about their pregnancy. Specific information was provided for women to ensure they sought the correct help depending on the length of their pregnancy and the concerns they had. For example, if a woman experienced reduced fetal movements and was more than 20 weeks pregnant she would be advised to immediately call or visit the triage service. Staff attended regular obstetric emergency drill training to ensure they could respond appropriately in an emergency. An RMO was available on-site 24/7 who could respond to emergencies and deteriorating patients, as well as a 24-hour cardiac arrest team. All RMOs had advanced life support (ALS) training. All theatre recovery practitioners were required to have immediate life support training. There were 16 staff members trained in neonatal life support (NLS). Women requiring management of complications were cared for in the high dependency room on the delivery suite. Any woman who required additional support and care would be transferred to the intensive therapy unit (ITU) of a sister hospital within the HCA group.

The maternity service used the World Health Organisation (WHO) surgical safety checklist for women having a caesarean section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The hospital audited compliance with the World Health Organisation (WHO) Five steps to safer surgery, including the surgical safety checklist. For December 2021 and January 2022, these audits showed 100% compliance. All records we reviewed showed that WHO checklist was fully completed by staff.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. A team of duty managers covered the hospital site 24-hours a day, seven days a week to provide clinical support and expertise to the inpatient and outpatient teams.

### Nurse and Midwifery staffing

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

The service had enough nursing and midwifery staff to keep women and babies safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, with a daily bed meeting where staffing was reviewed and amended where required to ensure all areas were safely staffed.

The antenatal and the postnatal ward had a minimum staffing of two midwives. The team worked to a 1:4 ratio with a supernumerary in-charge midwife, in addition to the midwife numbers. If a baby was receiving transitional care on the postnatal ward that baby would be added to the patient numbers for the ward and the staffing requirement was adjusted accordingly.

All women received one-to-one midwifery care during established labour in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

The ward manager could adjust staffing levels daily according to the needs of women. In the 12 months prior to our inspection, staffing turnover across the service averaged at 13.5%, with an average sickness rate of 4.8%. There were 14 vacant posts at the time of our inspection, although some of these vacancies were due to recruiting additional staff to the service. Senior leaders demonstrated they were actively recruiting into these vacancies, using a variety of methods to both recruit and retain staff. This was against a national backdrop of nursing shortages. In the same period, the average use of bank staff averaged 16% and the average use of agency staff was 5%. Staff working at the hospital were offered incentives to cover bank shifts. Managers made sure all bank and agency staff had a full induction and understood the service.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.**

The service had enough medical staff to keep women and babies safe. The hospital worked with consultants under a practising privileges arrangement and was able to demonstrate this process was robust, with strong medical governance arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent service. Each consultant obstetrician was on-call for their patients throughout their pregnancy and for their delivery. They provided individualised care for their women on the labour ward. Each consultant obstetrician worked within a team of consultant obstetricians, providing cross-cover arrangements. This meant there were multiple obstetricians on-call at any time.

For all elective high-risk elective caesarean section cases, a second obstetrician could be requested to be available to attend and assist at the delivery. This was planned and arranged through the complex care team and multidisciplinary team (MDT) meeting. Following this, a second on-call rota for anaesthetists would be put into place. This ensured that full anaesthetic support was available for the high-risk patient, in addition to continued anaesthetic support for other labouring women. This rota remained in place until the woman was deemed stable postnatally by the anaesthetist overseeing their care.

There was a 24 hour, seven-day resident medical officer (RMO) cover for the wards. All RMOs were required to have a current advanced life support certificate and were suitably experienced to work within maternity services. There was a total of five RMOs who worked at the hospital, with an average turnover of 21.7% and sickness rate of 0.42% over the last 12 months. In the same time period, agency cover of the RMOs was less than 1%. Midwifery staff on the wards told us they did not experience any problems in requesting medical review of women when needed.

### Records

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

Women's notes were comprehensive and all staff could access them easily. When women transferred from a midwifery led to a consultant led care, there were no delays in staff accessing their records. Records were stored securely. Women were given their own set of hand-held antenatal care records at the initial booking appointment. Women carried their own handheld pregnancy records, which staff documented on and advised women to bring at each antenatal appointment and on any occasion when they attended the hospital. This was in line with the NICE Antenatal care for uncomplicated pregnancies guideline. The hospital also held a copy of women assessment and care records in the

hospital to ensure timely access to the women's information for any high-risk cases. Women's booking and delivery details were recorded electronically. Women were given the national personal child health record (also known as the 'red book') by staff on discharge after birth. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

We reviewed nine records and found these were completed in line with national standards (NMC The Code: Professional standards and behaviour for nurses and midwives, 2015). The records we reviewed were contemporaneous, and entries were legible, signed and dated.

Regular clinical assessments by the multi-disciplinary team (MDT) were evident in the maternity records we reviewed. Clinical assessments of social, medical, obstetric and mental health had been documented.

At the last inspection, we saw poor documentation from consultants performing perineal repair. No details of the type or nature of repair were recorded. This is contrary to National Institute for Health and Care Excellence (NICE) guidance, which states that documentation should include a detailed account covering the extent of trauma, the method of repair and the materials used (NICE CG190, 2007). At this inspection, we found that relevant details were documented correctly.

### Medicines

**The service used systems and processes to safely prescribe, administer and record medicines. However, some medicines were not stored correctly.**

Staff followed systems and processes to prescribe and administer medicines safely. The service had access to an in-house pharmacy for advice on medicines. Staff completed medicines records accurately and kept them up to date. We looked at nine prescription charts during the course of inspection. All were clear and fully completed, with allergy status complete. Staff stored and managed all medicines and prescribing documents safely. An electronic system was used to administer medications and monitor stock levels. Controlled drugs were manually checked by two members of staff.

Room and fridge temperatures were monitored and controlled by an electronic system which alerted staff should there be any issues. At the time of inspection, the medicine fridge on postnatal ward was out of order and staff moved the medication to the nearest appropriate fridge in the nursery on the postnatal ward. However, we found that the fridge was not kept locked. We highlighted our concerns to senior leaders, who investigated it immediately and rectified the issue.

Emergency medicines were stored in tamper-evident trolleys and stored in an easily accessible area. We checked the medicines kept within the adult resuscitation trolley on the labour ward. Regular checks were carried out by staff and appropriate documentation was completed. Although all medicines were in date and a daily checklist was completed by the midwifery staff, we found that in March 2022, staff printed an old checklist and carried out the checks for the whole month without realising that not all emergency medicines within the adult resuscitation trolley matched the daily stock list. For example, the checklist stated that there should be five adrenaline (1mg pre-filled 1:10,000) in the trolley, but there were six in the drawer; one naloxone pre-filled syringe (2mg), but there were two in the drawer and two adrenaline 1:1000 injections, but there were none in the drawer. Adrenaline was available in the anaphylaxis box within the trolley in a different drawer. We highlighted our concerns to senior leaders, who investigated this immediately and rectified the issue. Post inspection, we were informed that all previous versions of the checklist were archived and in the same week an external provider of resuscitation services, carried out a further audit to ensure that the learning identified through the inspection had been implemented and that staff knew where to access the correct form.

During this inspection, we found the tamper proof seal of the medication box in the neonatal trolley on the labour ward was broken. We highlighted this to the Matron. Post inspection, we were told that the box was replaced by the pharmacy. The pharmacy manager also reviewed all of the boxes within the hospital and confirmed that all were intact, and a communication was sent to the team to ensure staff were aware that if the seals look torn or damaged that pharmacy was to be contacted to rectify this.

We also found some medicines in the pre-eclampsia container within the obstetric trolley, were not stocked correctly. For example, though the correct overall dose (20mgs) of nifedipine was within the container, the label (on the container) stated there should be 10mgs x two capsules when in fact there was 5mgs x four capsules. The medication boxes within the container contained the correct labels and were clearly identified as 5mgs x four capsules, but this did not match with the label on the main container. We also found four magnesium sulphate 1gm/2ml ampoules with two different expiry dates and from two different batches kept in the same box, with unclear labelling, which meant that in case of a recall staff would not be able to track the correct ampoules. We highlighted our concerns to senior leaders, who investigated it immediately and rectified the issue.

A range of medicine audits were conducted to ensure compliance with local and national guidance. They indicated appropriate actions were taken where any issues or omissions were identified. Staff learned from safety alerts and incidents to improve practice.

### 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with hospital policy. Staff told us they felt confident to report incidents and knew how to escalate concerns. In the 12 months prior to our inspection, the service reported 501 incidents. We saw they were graded by level of harm, with none identified as severe harm. The most common themes were incident related access, appointment, admission, transfer, discharge, labour or delivery and other (which included safeguarding incidents, COVID-19 and housekeeping related incidents).

Although most staff were able to give us examples of recent incidents that occurred within the service, staff had variable knowledge of any learning from these. The hospital was able to demonstrate it held a number of meetings to discuss such incidents and learning, but we were not fully assured all staff were aware of changes made to reduce the risk of incident reoccurrence.

The service held perinatal mortality and morbidity (M&M) meetings for any mortalities which were attended by multidisciplinary team staff. The circumstances and management of each neonatal death was discussed to determine if it was avoidable or unavoidable and any learning or action points shared if appropriate. All still births and neonatal deaths were investigated and reported to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) in line with the national guidance. MBBRACE launched the perinatal mortality review tool kit (PMRT) and the service used this tool to review perinatal mortality.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. We saw examples of duty of candour being applied and handled according to regulations with letters containing an explanation of the situation and apology.

Good

# Maternity

## Are Maternity effective?

Good

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

### Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies viewed as part of our inspection were found to be in date. Guidelines were available on the intranet and included sepsis management, baby abduction, deteriorating policy and medicine policies. There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to, in respect of postnatal care. For example, on the postnatal ward, staff supported women with breast feeding and caring for their baby prior to discharge.

### Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff fully and accurately completed women's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor women at risk of malnutrition.

There was a midwifery lactation team responsible for the oversight of infant feeding. All midwives working within this team have undertaken lactation consultant training. Women told us that they received support to feed their babies. Between March 2021 and February 2022, the initiation of breast-feeding rate ranged between 62% and 93%. Specialist support from staff such as dietitians was available for women who needed it. Babies with tongue tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast, causing feeding problems) were referred to a neonatal clinic where the doctor could divide the tongue tie if required. This meant that women and babies received timely intervention when feeding was complicated by tongue tie.

### Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women were provided with evidence-based care and information about the availability and provision of different types of analgesia. This was in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013). Pain relief and control was discussed with women during their birth plan appointment and women were able to choose their choice of pain relief.

Good

# Maternity

Women were able to access pain relief during birth and post operatively in a timely way. Nitrous oxide (a pain-relieving gas) was piped in all delivery rooms. Stronger painkiller by injection was available for women who required stronger pain relief. A birthing pool was also available so women could use water immersion for pain relief in labour of they wished. During the inspection, women told us they could access pain relief during birth and post operatively in a timely manner.

Staff prescribed, administered and recorded pain relief accurately. Epidurals (an injection of anaesthetic into the spinal area) were available 24 hours a day and most women who requested epidural anaesthesia received it within thirty minutes. Between March 2021 and March 2022, 99% of women who had elective or emergency caesareans received regional anaesthesia.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.**

The service participated in relevant national clinical audits including the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). Results from the 2019 report demonstrated that both the stillbirth and neonatal rates were similar to or lower than, those seen across similar hospitals and health boards. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time via an audit and effectiveness committee to monitor completion and compliance. Managers used information from the audits to improve care and treatment.

The service used a maternity dashboard to monitor various key performance indicators and outcomes. Managers and staff used the results to improve women's outcomes. Between July 2021 and February 2022 information on the dashboard demonstrated that: There were 944 women delivered 960 births at the hospital. The elective caesarean section rate ranged between 36% and 52%, the emergency caesarean rate ranged between 18% and 22%, which was higher in August 2021, January 2022 and February 2002 than the hospital goal standard of less than 20%. The instrumental delivery including ventouse and forceps delivery rate ranged between 8% and 16%, which was within the hospital goal standard of less than 20%. There was one case of a third- or fourth-degree tear reported which was within the hospital standard. There were eight cases of massive obstetric haemorrhage of 1500 millilitres which was within the hospital standard and equated to 0.8% of patients.

The service complied with national key performance indicator (KPI) monitoring, which included recording numbers of unplanned readmissions, unplanned returns to theatre and unplanned transfers. In the 12 months prior to our inspection, there were 1534 discharges from the service, including 15 (0.98%) unplanned readmissions, four (0.26%) unplanned returns to theatre and one (0.07%) unplanned transfer.

## Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. Staff annual appraisal rates stood at 96% at the time of inspection.

The practice development midwife supported the learning and development needs of midwifery staff. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Clinical staff told us that they

were given time to attend meetings. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example; multidisciplinary simulated 'core skills' training also took place for maternity staff to maintain their skills in obstetric emergencies.

### Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. These meetings were attended by a variety of staff, with input from specialists were indicated. A handover took place twice a day on the labour ward. The handover used a maternity specific handover sheet and included an overview of all maternity patients.

There was effective multidisciplinary working between the midwives, obstetricians and neonatal staff. Staff worked closely with others in different teams to involve them in care planning depending on the needs of the woman and baby. Pregnant women with complex care needs were discussed at a weekly complex care meeting led by maternity matron and virtually attended by multidisciplinary specialist including theatre and neonatal lead.

### Seven-day services

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

Consultant obstetricians and anaesthetists were available on-call 24-hours a day, seven days a week. There was a resident consultant anaesthetist who provided cover 24-hours a day, seven days per week on the labour ward. Each consultant obstetrician was on-call for their patients throughout pregnancy and for delivery. They provided individualised care for their women on the labour ward. Each consultant obstetrician worked with a team of consultant obstetricians providing cross-cover arrangements. Therefore, at any given time there were multiple obstetricians on-call.

There was 24-hour access to a dedicated emergency obstetric theatre and the theatre team was also available 24 hours a day, seven days a week. The hospital employed resident medical officers (RMOs) for obstetrics and gynaecology who worked either a 12- or 24-hour shift. Staff could call for support from doctors and other disciplines and diagnostic tests, 24 hours a day, seven days a week.

### Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. At the initial booking appointment midwives screened for risk factors such as raised body mass index, low blood haemoglobin levels and smoking. These were discussed with the woman and used to inform care planning and advise the woman accordingly. The hospital had introduced an online app called 'The Portland App' which had content and information to support women during their pregnancy and advice to lead a healthier lifestyle. A range of parent education classes, including antenatal and postnatal exercise classes were offered.

Good

# Maternity

### Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. The hospital had a consent policy that took account of relevant legislation and guidance, which was accessible by all staff. When pregnant women could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records. All nine records we reviewed demonstrated staff clearly recorded consent. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

## Are Maternity caring?

Good

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

### Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Services were provided in single rooms with en-suite facilities which ensured privacy and dignity for patients receiving care. We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited into the patient's room. All of the four women we spoke with said staff treated them well and with kindness. Staff followed policy to keep women's care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Between December 2021 and February 2022, in the monthly inpatient survey, 100% of women said they were given enough privacy when discussing their care.

### 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. We observed midwives, clinicians and nursing staff alike introducing themselves to women and women responding positively to this. Women and relatives told us they felt listened to and said all staff were "excellent" and "helpful".

The hospital did not employ a specialist bereavement midwife, but bereavement support was offered to women who had experienced a late miscarriage or still birth. All midwifery staff were responsible for ensuring bereavement facilities were adequate and that all literature was up to date for supporting families. Bespoke bereavement documentation

packages were available for both early and late pregnancy losses. Memory boxes were assembled for parents who suffered pregnancy loss. A cold cot was available which meant that babies could stay longer with parents. However, at the time of inspection, there was no mattress in the cold cot and staff informed us that a new mattress has been ordered.

Multifaith chaplaincy and spiritual support was available 24 hours a day and seven days per week to provide emotional support to women and those important to them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Outpatient perinatal psychiatrist service was available to any women who require support before, during and after pregnancy.

### 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 that they felt well informed and able to ask staff if they were not sure about something.

The postnatal ward's nursery was staffed with nursery nurses, who provided new parents with newborn care advice. Due to COVID-19, the nursery was recently reopened to accommodate five babies during night-time to ensure safe distancing and there were plans to open it to normal 24 hours in the near future.

Pregnancy open days provided parents with the opportunity to know the services available at the hospital. Due to COVID-19 visits and tours of the facilities, including delivery suites and postnatal bedrooms were not taking place, but virtual videos were available on the hospital website. Pricing information about midwifery -led and consultant-led packages were also available on the hospital website. The hospital offered a 'meet and greet' appointment with a midwife which gave women the opportunity to discuss their antenatal and birth options. Staff supported women to make informed decisions about their care. Women and their families could give feedback on the service and their treatment and staff supported them to do this. All women we spoke with gave positive feedback about the service. Over the last three months, 100% of women said they would either be 'extremely likely' or likely' to recommend the service to friends and family.

## Are Maternity responsive?

Good

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

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of women.**

Managers planned and organised services, so they met the needs of women. Women could access the maternity services either by contacting the consultant obstetricians directly, or for midwife-led care, they could contact the hospital antenatal clinic. Women were given a choice of times and dates for antenatal clinic appointments. Both

midwife-led and consultant-led care packages offered a full range of birthing options. Women were given an informed choice as to how they wished to give birth. Facilities and premises were appropriate for the services being delivered. All rooms on the antenatal and postnatal ward were equipped for a woman's partner or relative to stay overnight. The service had systems to help care for women in need of additional support or specialist intervention.

Postnatal follow-up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The 'red book' was issued on transfer to the postnatal ward. This facilitated ongoing care and monitoring of the baby until five years of age. Managers monitored and took action to minimise missed appointments. Staff informed us that this was rare and staff ensured that women who did not attend appointments were contacted. The hospital worked with local NHS trusts as part of the national arrangement with independent healthcare providers during the COVID-19 pandemic.

### Meeting people's individual needs

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

The needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment were coordinated with other services and providers, to ensure the needs of women and their families were met. Birth partners and doula's were allowed during labour and in theatre for elective caesarean section. Each woman had an individualised plan of care clearly detailed in their notes. The hospital offered a wide range of childbirth preparation classes including yoga classes, hypno-birthing, yoga classes and preparation for caesarean section. A birth reflection service was available on an ad hoc basis. Women were also able to access integrated therapies such as physiotherapy and dietitians for nutritional advice and support.

The birth centre birthing rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. A birth pool was located in one of the rooms for women who wished to use water immersion for pain relief in labour.

There was no dedicated bereavement room and most prenatal events were managed on the gynaecology floor away from labouring women. Families could also be cared for in any single room in the delivery suite. The layout of the delivery suite was appropriate for this. Following delivery, women were transferred to the gynaecology ward on the fourth floor. The hospital ensured that arrangements for post-mortem examination met the legal requirements. All bereaved parents discussed recent events and future options with a consultant obstetrician.

The hospital's international office managed all aspects of care for international patients throughout their pathway. Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. On site Arabic interpreters were available Monday to Friday from 8am to 8pm. There was an out of hours service. The hospital was also signed up to a telephone interpretation service which was available 24 hours a day, seven days a week. Information leaflets were available in various languages via 'the Portland App'.

### Access and flow

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

Good

# Maternity

Between March 2021 and February 2022, there were 12682 consultations, 73 day case procedures, 1461 inpatient episodes and 15137 outpatient appointments across the service. In the same reporting period, there were 1413 deliveries, which resulted in the birth of 1430 babies (figure discrepancy due to multiple pregnancies).

Women could access the maternity service via their consultant or by direct referral. Consultant-led care was available for women, irrespective of risk. The consultant obstetrician arranged the hospital booking for delivery and offered an informed choice on all types of birth, from normal deliveries to caesarean sections. Women booked under the care of a consultant obstetrician attended the midwifery booking clinic. Here, advice was provided on nutrition, health and well-being throughout pregnancy, as well as giving women the opportunity to discuss birth plans. Women could also elect for midwife-led care. This package included all antenatal appointments, ultrasound scans, routine blood tests and a 24-hour stay post-delivery.

Managers and staff started planning each woman's discharge as early as possible. Daily bed meetings ensured there were sufficient beds and staff for expected admissions the following day and identified potential issues. Along with discharge planning meetings, this helped to prevent delayed discharges and staffing issues.

### Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Between February 2021 and January 2022, the service received 22 formal complaints. The majority of these related to communication, quality of care and customer services. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service was signed up to an independent review service for resolution of formal complaints, but no complaints had been escalated to them for review in the 12 months prior to inspection.

## Are Maternity 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 patients and staff. They supported staff to develop their skills and take on more senior roles.**

There was a clear management structure which staff were aware of. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood. The chief nursing officer, supported by the chief medical officer, was responsible for the provision of maternity services. The head of midwifery was supported by

clinical matrons, a clinical practice development facilitator and a lactation education midwife, lead of midwifery led care and labour ward sisters. Staff were mostly positive about their immediate line manager and senior leaders and felt they were visible and approachable, and welcomed feedback about the service. There was some dissatisfaction, where staff felt that their concerns about bullying and harassment had not been taken seriously until it was raised with the chief executive officer and the chief nurse.

Leadership training was available for staff. Senior leaders visited each department regularly, with informal weekly sessions held with the chief nurse and a monthly forum with the chief executive officer.

### 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.**

Staff were passionate about doing the best job for the patient and were proud of the work they did in the service. Staff we spoke with told us the hospital was committed to delivering safe and effective clinical care. The hospital's aim was to 'be recognised as the number one hospital in the UK dedicated to the care of women and children'. Their 2021-24 strategy focused on four strands: exceptional care, people, quality and operational excellence and clinical pathway development. This included the redevelopment of the hospital, and although there had been some delays due to COVID-19, there were clear timelines to refurbish ward areas, create a new urgent care centre, develop a hybrid theatre and create a new wellbeing centre for staff and families. There was also focus on recruiting and retaining more staff and developing specialties such as complex spinal surgery for children. Leaders told us the vision and strategy had been developed with the engagement of staff. Staff we spoke to where aware of the future direction of the hospital.

### Culture

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

Staff we met were welcoming, friendly and helpful. The majority of staff we spoke with were positive about the service and told us they were respected, supported, and valued. However, some staff groups felt that their role and contribution in particular during COVID-19 pandemic was not recognised compared to other teams.

A diversity and inclusion committee operated at provider level, with representatives from the hospital. The chief executive officer had attended training on inclusive leadership, with a further day planned to develop a diversity and inclusion strategy. However, not all staff were aware of these developments. The hospital celebrated a number of celebrations from different religions and cultures throughout the calendar year. There were freedom to speak up champions within the service to support staff to raise concerns and a Freedom to Speak up Guardian at corporate level. Staff we spoke with were aware of the freedom to speak up champions and how to contact them.

### Governance

**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**.

Good

# Maternity

The service had a well-defined governance and risk management structure which ensured information flowed from ward and service level to the monthly hospital board meeting. Chaired by a consultant paediatrician, the medical advisory committee (MAC) ensured all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake treatments they provided. We reviewed the last three months minutes of the quality governance meeting and saw all aspects of governance were scrutinised, including incident reporting and management, infection prevention and control, complaints, friends and family data and the risk register. Staff conducted a range of audits to assess clinical effectiveness. We saw audit results, along with patient outcome data, complaints and incidents were discussed and reviewed at relevant meetings.

## 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.**

The maternity risk register fed into the hospital wide risk register and both were reviewed regularly. The risk register recorded the location of risks, a brief analysis, a description, the severity and likelihood rating, any mitigation measures, a responsible person and a target date to review. There was a policy for risk management and the service undertook various risk assessments. Most of the risks we identified on inspection were on the risk register, with senior staff aware of issues such as non-functioning baby tagging system and mitigations were in place. There was a business continuity policy which detailed what to do in the case of unexpected emergencies. The service was responsive to the areas of improvement and took immediate actions to rectify risks identified during the inspection, such as an unlocked medicine fridge on the postnatal ward.

## 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 had a maternity quality dashboard which was shared with all staff and outlined key performance, risks, complaints, incidents and feedback. All policies were available for staff to access via the hospital intranet.

Patient information and records were stored securely on all the wards and in all departments we visited. During the inspection we observed staff treated patient identifiable information in line with General Data Protection Regulations (GDPR).

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public to plan and manage services.**

Patients were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the hospital website, social media and email. This feedback was shared with staff and used to drive improvement. Patient stories were collected and featured in patient information. The service was not offering any tour of the unit during COVID-19, but tour videos were available on the hospital website. The website and parenting

magazine included useful information for all users of the service. For example, there was a listing and details of the antenatal classes offered and details of integrated services available. The hospital annually celebrated World Prematurity Day to raise awareness of premature births and how this can affect families and families of preterm babies delivered at the hospital were invited.

All staff we spoke with told us how the hospital engaged with them during the refurbishment of the antenatal and postnatal ward and how other departments worked with maternity service to ensure minimal impact on patients. Staff were able to give feedback via the six-monthly staff engagement surveys. The results in October 2021 showed a decline from the previous survey on most measures, with the majority of staff who responded (47%) saying they wanted a greater focus on staffing and equipment and technology from managers. The service offered listening opportunities for staff where they could meet and engage with senior leaders. There was a staff newsletter and a variety of reward schemes for recognising staff achievement. During COVID-19, a number of wellbeing initiatives had been established to support staff.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services.**

Senior leaders explained how their clinical practice, systems and processes were always in line with latest research and guidance. Senior leaders took immediate action in response to issues identified during this inspection visit. For example, rectifying the issues related to medication stock and checks of the resuscitation trolley on labour ward and ensuring that the temporary medicine fridge in the nursery is kept locked. Staff were committed and passionate about improving the service they provided.

Good

# Services for children & young people

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are Services for children & young people safe?

Good

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

### Mandatory training

**The service provided mandatory training in most key skills to all staff and made sure everyone completed it.**

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of children, young people and staff. For all non-medical staff across the service, the compliance rate with mandatory training modules stood at 91%, against a hospital target of 85%. However, compliance was lower than expected for some nursing staff competencies in the paediatric intensive care unit (PICU), particularly intravenous infusion training (76%) and drugs by direct injection (83%). Senior staff told us this was due to higher levels of sickness absence due to COVID-19. The hospital ensured fully competent staff were on shift at all times. Figures provided for May 2022 showed that compliance levels for these two competencies had improved to 100% and 97%, respectively.

For resident medical officers (RMOs), training rates stood between 86% and 100% at the time of inspection. Staff received training in sepsis management. Managers monitored mandatory training and alerted staff when they needed to update their training.

### Safeguarding

**Staff understood how to protect children, young people and their families 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.**

Nursing and medical staff received training specific for their role on how to recognise and report abuse. National guidance specifies all clinical staff working closely with children and young people should receive training in level three safeguarding. Data provided demonstrated 95% of staff in the department had completed safeguarding adults level two training and 94% of staff had completed safeguarding children level two training. In addition, 94% of staff had completed level three safeguarding children training at the time of inspection. Staff knew how to identify adults and children at risk

of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were dedicated leads for safeguarding and an individual on shift with a level four safeguarding qualification 24 hours a day, seven days a week. In the 12 months prior to our inspection, the hospital had made 21 safeguarding referrals.

The service had a policy in place for chaperoning children and young people and staff received training in this.

Staff followed safe procedures for children visiting the wards. Entrances to the wards, including lifts, were secured with electronic swipe access via a staff identification badge. Admittance to the wards for relatives and carers were controlled by staff. At the time of inspection, the inspection team identified concerns about the staffing levels of the on-site security team. Senior staff assured us that they mitigated security risks through a range of measures and that additional support could be offered by the front of house and portering team, but they would review security staffing levels and ensure these were appropriate.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.**

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The hospital used “I am clean” stickers to indicate when patient equipment had last been cleaned and was ready for use by another patient.

Staff followed infection control principles including the use of personal protective equipment (PPE). In all areas we visited we observed staff had access to adequate quantities and type of PPE. Throughout the hospital there was sufficient access to hand washing sinks and equipment washing sinks, soap, and alcohol gel hand rub. We observed staff washing their hands and following the World Health Organization’s five moments for hand hygiene guidance.

A range of audits indicated good compliance with infection prevention and control policies and procedures, with appropriate actions taken where any issues or omissions were identified. Between March 2021 and February 2022, the service reported one surgical site infection, one case of MRSA and six cases of Clostridium difficile.

The service took appropriate measures to reduce the risk of COVID-19 transmission. This included regular testing of both patients and staff, social distancing within the hospital, and use of appropriate PPE. Toys were wipe clean and cleaned after each patient use.

### 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.**

Children, young people and their families could reach call bells and staff responded quickly when called. All children and young people on inpatient wards were cared for in single en-suite rooms.

Good

# Services for children & young people

Staff carried out daily safety checks of specialist equipment. An external company maintained and serviced equipment through an annual contract. During our inspection we saw resuscitation trolleys were available in all the areas we inspected and contained emergency equipment and medicine, available and fit for purpose, for all age ranges of children and young people. The resuscitation trolleys throughout the CYP service contained both adult and paediatric medication, with a risk assessment in place to ensure this was managed.

The service had enough suitable equipment to help them to safely care for children and young people. Equipment had electronic service testing stickers clearly visible, indicating to staff when equipment had last been serviced and that it remained appropriate to use. However, staff we spoke to whilst on inspection told us equipment shortages and delays in fixing or collecting broken equipment did occur. This meant there was some clutter in areas of the hospital.

The recovery area in the theatres was separate for paediatric patients and contained two beds. This was screened off from the area used by adults, but the area did not have child friendly decorations.

Staff disposed of clinical waste safely. The service had arrangements in place for the handling, storage and disposal of domestic and clinical waste and sharps. We saw clinical and non-clinical waste was segregated into colour coded bags and sharp objects were deposited in sharps bins.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.**

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff carried out observations using paediatric early warning scores (PEWS). Observations were recorded using an electronic system which alerted relevant members of staff if a patient's condition deteriorated. If a patient did deteriorate then the resident medical officer (RMO) would be alerted automatically. However, some staff on inspection told us issues with the Wi-Fi sometimes meant there were issues with accessing the electronic system at times. In this case, they would enter observations directly into the electronic notes or revert to paper-based recording. Staff could call the RMO directly to attend to a patient where observations caused concern. The hospital audited the completion of PEWS and took actions where any issues were noted.

The hospital had a pre-operative assessment team which provided advice and information to patients prior to their surgery, including tests and screening. The service had an inclusion and exclusion criteria outlining the different exclusion criteria for their inpatients, outpatients, urgent care and day surgery paediatric patients. The service did not accept surgical emergencies and all patients were elective. Patients attending the urgent care service were by appointment only and were triaged over the telephone by a nurse or doctor who had received training in telephone triage. Any patients directed to seek help elsewhere were followed up to ensure they had taken the advice given at the time of triage.

The paediatric site practitioners (PSPs) provided support to the wards 24 hours a day, seven days a week to assist with the assessment and management of a deteriorating child. If a deteriorating child required transfer, the nine-bedded PICU catered for those requiring level 3 care, with an additional five level 2 beds available if required. The neonatal unit had three level 2 beds and three level 1 beds. Other critically ill children or babies were transferred via ambulance to a local NHS trust. A transfer agreement was in place. An RMO was available on-site 24/7 who could respond to emergencies and deteriorating patients, as well as a 24-hour cardiac arrest team. An on-call consultant was also available at all times. All theatre recovery practitioners were required to have immediate life support training. All staff in the urgent care centre were trained in European Paediatric Advanced Life Support (EPALS). Across the service, staff compliance levels with the appropriate level of life support training stood at between 97% and 100%.

Good

# Services for children & young people

Staff completed risk assessments for each child and young person on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. On the day of inspection, we observed one patient undergoing surgery was not safely marked on the ward as per policy. The hospital assured us this was an isolated incident and retrospectively audited notes between December 2021 and January 2022, as well as completing an observational audit of 20 patients to assure us this was the case. An aide memoir was circulated to all staff and the hospital planned to audit this closely in future to ensure patients do not leave a ward without the checking procedure taking place. The hospital audited compliance with the World Health Organisation (WHO) Five steps to safer surgery, including the surgical safety checklist. For December 2021 and January 2022, these audits showed 100% compliance.

In September 2020, the paediatric surgical cardiac programme transferred from another London HCA hospital to the Portland Hospital. However, at the time of inspection, cardiac catheter laboratory services remained at this sister hospital whilst the hospital redevelopment programme took place. These children travelled between the two sites in a hospital owned ambulance. The service had completed a risk assessment and standard operating procedure to manage this risk and ensure safe patient transfer took place with staff trained in the appropriate level of life support.

### Nurse staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**

The service had enough nursing and support staff to keep children and young people safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, with a daily bed meeting where staffing was reviewed and amended where required to ensure all areas were safely staffed.

Staffing on the paediatric wards met the Royal College of Nursing (RCN) guidance on staffing ratios, with one nurse for every three patients under two years and one nurse for every four patients over two years. One to one nursing could be provided where necessary. There was always a minimum of two registered children's nurses at all times across the inpatient and day case wards. In the 12 months prior to our inspection, there were three instances where last minute sickness or cancellations meant nursing ratios were not met on the inpatient wards. In these cases, appropriate mitigations were taken.

In the paediatric intensive care unit (PICU), one to one nursing was achieved, with one nurse to two patients in the high dependency (HDU) overflow beds. This was in line with Paediatric Intensive Care Society (PICS) standards, with a supernumerary nurse in charge and runner present on all shifts. In the 12 months prior to our inspection, there were ten instances in which it was flagged some patients were not nursed in line with these standards due to last minute sickness or shift cancellations. In these cases, mitigations were taken, such as nursing some patients with lower acuity with two nurses and senior nursing staff stepping in to work clinically.

In theatre recovery, all paediatric patients received care from two members of staff until the child was sufficiently recovered. There were five operating department practitioners with specific training in paediatrics.

Good

# Services for children & young people

In the 12 months prior to our inspection, staffing turnover across the service averaged at 16.2%, with an average sickness rate of 7.1%. There were 17 vacant posts at the time of our inspection, although some of these vacancies were due to recruiting additional staff to the service. Senior leaders demonstrated they were actively recruiting into these vacancies, using a variety of methods to both recruit and retain staff. This was against a national backdrop of nursing shortages and was on the service's risk register.

In the same period, the average use of bank staff averaged 12.3% and the average use of agency staff stood at 20%. Staff working at the hospital were offered incentives to cover bank shifts. Managers made sure all bank and agency staff had a full induction and understood the service.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 children and young people safe. Patient care and treatment was consultant led, with consultant cover arrangements in place 24 hours a day, seven days a week. The hospital worked with consultants under a practising privileges arrangement and was able to demonstrate this process was robust, with strong medical governance arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent service.

There was 24 hour, seven-day resident medical officer (RMO) cover for the wards. During the day on weekdays, two RMOs provided cover, with one RMO covering during the night and weekends. There were a total of 26 RMOs who worked at the hospital, with an average turnover of 11.7% and sickness rate of 2% over the last 12 months. In the same time period, agency cover of the RMOs averaged 0.4%.

The operating surgeon and anaesthetist were available for inpatients requiring unplanned surgery. There was an on-call paediatric anaesthetic consultant rota for emergency returns to theatre.

## Records

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

Patient notes were comprehensive, and most staff could access them easily. Records were stored securely. All notes in the paediatric intensive care unit (PICU) were electronic, but throughout the rest of the hospital, a mix of paper-based and electronic notes were used. Locum RMOs and agency nursing staff could not access the electronic notes, which could cause some fragmentation in regard to record keeping.

We reviewed 13 patient records across the PICU, day case ward and inpatient wards and found all of them had an adequate diagnosis and management plan documented and signed. There were four records that did not contain all risk assessments, although the majority of risk assessments were completed. The notes were legible and comprehensive. The service carried out monthly audits of documentation across the hospital and any issues were identified, with appropriate actions taken to improve compliance.

## Medicines

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

Good

# Services for children & young people

Staff followed systems and processes to prescribe and administer medicines safely. The service had access to an in-house pharmacy for advice on medicines. Staff completed medicines records accurately and kept them up to date. Patient records documented patient height and weight to enable the appropriate medicine dosage to be prescribed.

Staff stored and managed all medicines and prescribing documents safely. An electronic system was used to administer medications and monitor stock levels. Controlled drugs were also manually checked by two members of staff. Room and fridge temperatures were monitored and controlled by an electronic system which alerted staff should there be any issues. A range of medicine audits were conducted to ensure compliance with local and national guidance. They indicated appropriate actions were taken where any issues or omissions were identified.

Staff learned from safety alerts and incidents to improve practice. However, in the CYP service there had been 105 medicines incidents reported in the 12 months prior to our inspection, all resulting in low or no harm. Following a spike in incidents last summer, a review of medications was carried out within the department and several factors including the higher use of agency nursing staff had been identified. As a result, training in medication administration had been rolled out to agency staff.

### Incidents

**The service managed patient 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 children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff used the hospital's incident reporting system to report incidents. Staff told us they felt confident to report incidents and knew how to escalate concerns. In the 12 months prior to our inspection, the children's service reported 981 incidents. We saw they were graded by level of harm, with one identified as severe, two as moderate, 364 as low and 604 as no harm. The most common themes were other (which included safeguarding concerns, COVID-19 related incidents and incidents with family members), medication, and incidents relating to access, appointments, admission and transfer discharge. The incident rated as 'severe' was reported as a serious incident (SI) requiring investigation, with a root cause analysis investigation undertaken. The service held monthly mortality and morbidity meetings which were well-attended. Cases were fully discussed with actions agreed where appropriate.

Some staff were able to tell us about incidents such as medicine errors that had occurred and staff training provided as a result, or pathology results not being communicated to patients and processes put into place to remedy this. However, there was variable knowledge of incidents that occurred across the service, with not all staff able to articulate what incidents had occurred or any learning from these. The hospital was able to demonstrate it held a number of meetings to discuss such incidents and learning, but we were not fully assured all staff were aware of changes made to reduce the risk of incident reoccurrence.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. We saw examples of duty of candour being applied and handled according to regulations with letters containing an explanation of the situation and apology.

## Are Services for children & young people effective?

Good

# Services for children & young people

Good

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

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a sample of policies and guidelines related to children and young people and found they were easily accessible to staff, were approved and within their review date. The selection of clinical policies all referenced relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.

### Nutrition and hydration

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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. A variety of food choices were available to children 24 hours a day, which included a selection of snacks. Staff followed national guidelines to make sure children fasting before surgery were not without food for long periods. A member of staff had designed a fasting wheel for use by families and staff which indicated when a child could be fed and drink water prior to surgery and acted as an aide memoir to inform staff if an operation had been delayed for more than two hours so a review of their fasting times could be initiated.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists was available for children and young people who needed it. There were provisions in place for breast feeding mothers in the neonatal intensive care unit (NICU) and fridges in place to store breast milk for new-borns.

### Pain relief

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

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff had access to pictorial aids for children to communicate pain levels and effectiveness of pain relief. Children and young people received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Patients' records showed the level of pain was assessed regularly and all parents and children we spoke with were satisfied their pain was well-controlled. Pain management was audited on a monthly basis and patients were asked about their pain in the hospital's patient survey, with any issues identified and acted upon.

Play specialists were used to assist children in preparing for procedures. Distraction and relaxation techniques were used to help children manage any pain. Staff applied topical anaesthetic cream to children and young people prior to blood tests to relieve any pain and discomfort during the procedure.

Good

# Services for children & young people

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.**

The service participated in relevant national clinical audits. The neonatal service contributed information to a shared electronic database but was unable to participate in the audit programme attached to this as it was reserved for NHS centres. The paediatric intensive care unit submitted data to the Paediatric Intensive care Audit (PICANet), a national audit on all children admitted to intensive care units across the UK. The PICANet 2021 data showed PICU performance to be within accepted thresholds across all measures, with two exceptions. These were the proportion of admission records completed within three months of discharge (83.5% against a national average of 89.2%) and the number of registered and non-registered nursing staff providing clinical care in post (WTE) per bed by band, which was below the recommended PIC standard of 7.1 WTE staff per level 3 intensive care bed. This was due to vacancies in the service and the shortfall was managed with agency nursing staff to maintain safe nursing levels. As the results had only been shared with the hospital in January 2022, an action plan had not yet been drawn up, but there were appropriate governance and monitoring processes planned to do so.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time, with an audit and effectiveness committee to monitor completion and compliance. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The service complied with national key performance indicator (KPI) monitoring, which included recording numbers of unplanned readmissions, unplanned returns to theatre and unplanned transfers. In the 12 months prior to our inspection, there were 4127 discharges from the service, including seven (0.2%) unplanned readmissions, four (0.1%) unplanned returns to theatre and three (0.1%) unplanned transfers.

## 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 children, young people and their families. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Most staff were positive about career development and training opportunities in the hospital. For example, staff in the neonatal unit were given the opportunity to work for a two-week supernumerary period in an NHS specialist children's hospital to enable them to refresh their skills.

The resident medical officers were supported and funded to complete PhDs and masters level courses in medical management and leadership. They had completed projects on workforce planning and MDT meetings to drive improvement across the service.

Managers gave all new staff a full induction tailored to their role before they started work. The service had an induction programme in place for all newly recruited staff, including a supernumerary period that enabled staff to be familiarised with the hospital's systems and processes. New staff were positive about their experiences of starting work at the hospital and the induction process.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff annual appraisal rates stood at 89.4% at the time of inspection. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Good

# Services for children & young people

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. These meetings were attended by a variety of staff, with input from specialists were indicated. Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. There was effective daily communication between multidisciplinary teams within the hospital. Most staff told us they enjoyed working with their colleagues and were complimentary about the support they received from one another. Some staff felt their working relationships with doctors could be variable, but most felt confident any reported issues would be dealt with appropriately by the leadership team.

## Seven-day services

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

The outpatient service and urgent care centre (currently appointment only) was open from 8am to 8pm. A range of appointments were available to enable children and young people to attend with minimal disruption to their school attendance.

There was appropriate medical cover, including 24-hour, seven-day RMO cover and access to consultants on call should patients require urgent review. An on-call theatre team and consultant anaesthetist were available for emergency surgery.

Diagnostic imaging was available between 8am and 8pm Monday to Friday, and between 9am and 5pm on Saturdays. On Sundays, an on-call service was available. Professionals such as dietitians and pharmacists were available on call during weekends. At the time of inspection, play specialists did not work weekends, but the service was currently recruiting into two posts and wanted to extend to covering Saturdays too.

## Health promotion

**Staff gave children, young people and their families practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support across the service. For example, there was a health promotion board within the urgent care centre. Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. Pre-assessment staff discussed all necessary information with children and families about their operation and their health to identify potential risks and if any additional support or interventions were required.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. The hospital had a consent policy that took account of relevant legislation and guidance, which was accessible by all staff. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. All records we reviewed demonstrated staff clearly recorded consent.

Good

# Services for children & young people

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Staff were able to tell us about an example of a long-stay patient who required a best interests decision to be made and how this was managed.

## Are Services for children & young people caring?

Good

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

### Compassionate care

**Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for children, young people and their families. Staff followed policy to keep care and treatment confidential. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Children, young people and their families said staff treated them well and with kindness. We spoke with four parents and two children who all provided positive feedback about the treatment and care they had received from staff. They told us staff were “great” and they were “very happy” with their hospital experience.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff we spoke with provided examples of how they adapted care and treatment to individual patient needs, such as arranging appointments to avoid religious festivals.

Patients were also encouraged to give feedback via a patient satisfaction questionnaire. This was electronic across most of the hospital, with paper feedback cards still used in the urgent care centre and outpatient department. Over the last three months, 100% of parents and children said both the doctors and nursing staff were ‘good’, ‘very good’ or ‘excellent’.

### Emotional support

**Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.**

Staff gave children, young people and their families help, emotional support and advice when they needed it. During our inspection, we observed staff spending time with children to provide advice and support. Children and parents we spoke with told us they felt they were given enough support and advice by staff. However, staff did not receive formal training in delivering bad news.

The hospital had a team of named clinical nurse specialists who supported patients through their hospital journey end-to-end, from initial consultation to post-discharge. There was also a team of four full-time play specialists available to support children before, during and after their procedures, dependent on need. Feedback from staff and families regarding their support and input was overwhelmingly positive. The service was recruiting into an additional post to ensure there were enough play specialists to cover the increased workload post-COVID. A part-time music therapist was also available to support children and often ran joint sessions with this team.

Good

# Services for children & young people

### Understanding and involvement of patients and those close to them

**Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**

Staff made sure children, young people and their families understood their care and treatment and were supported to make informed decisions about their care. Children and families we spoke with told us they felt involved in their care plan and they were given opportunities to ask questions about their treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. For example, play specialists explained pre-operative or MRI procedures to children in a way they could understand, using a range of pictorial aids and equipment. Written information leaflets were available for patients about a range of treatments and procedures, including costs.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Child friendly versions of patient feedback forms were available. Patients gave positive feedback about the service. Over the last three months, between 97.1% and 100% of patients said they would either be 'extremely likely' or likely' to recommend the service to friends and family.

## Are Services for children & young people responsive?

Good

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

### Service delivery to meet the needs of local people

**The service did not always plan and provide care in a way that met the needs of patients. The service worked with others in the wider system and local organisations to plan care.**

Admissions to the surgical ward were elective and planned in advance. A range of clinics were held in outpatient departments to facilitate patient choice. Managers ensured that children, young people and their families who did not attend appointments were contacted.

Not all facilities and premises were appropriate for the services being delivered. At the time of inspection, only the imaging department and some ward areas were adapted to meet the needs of children. However, the anaesthetic and recovery areas in the imaging department were not child friendly, along with the day case ward and theatre environment. Senior staff told us the planned refurbishment for these areas would include a more child friendly design, but this was not the case at the time of our inspection. They told us projectors had been ordered to help create more child friendly environments. In the day case ward, some pictures had been put up by ward staff to make the environment more child friendly whilst they waited for the refurbishment to take place. We saw the plans for the redevelopment of the hospital, which had clear timelines, although there had been delays in achieving these due to COVID-19.

The hospital had worked with NHS trusts during COVID-19 to help manage waiting lists, and continued to do so with spinal surgery. The hospital engaged with a range of networks, including neonatal networks to ensure governance and risk issues were shared and addressed.

Good

# Services for children & young people

## Meeting people's individual needs

**The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.**

Staff made sure children and young people living with learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. For long stay children, there was an interim agency teacher in place as the contract with the previous provider of school services had ended shortly before our inspection. There were plans in place to provide a sensory room for these children and young people, with refurbishment of some ward areas already started. Distraction boxes were available in the outpatient department and urgent care centre.

The service did not accept children who had been recently hospitalised due to a mental health diagnosis or had recent episodes of self-harm. The service was currently recruiting into a part-time post for a psychologist but had an interim part-time psychologist in post at the time of inspection. Staff told us additional help could be requested from a psychologist from another London HCA hospital if required. Additionally, two consultant psychiatrists had practising privileges at the hospital if onwards referral was required. Young people were also provided with numbers of support helplines and charities they could contact confidentially. In the urgent care centre, staff knew who to contact if they had concerns about a child's mental health and directed these families appropriately.

Not all areas were designed to meet the needs of children, young people and their families. Due to COVID-19, the playrooms had been closed and toys were now taken directly to children's rooms instead. At the time of inspection, there was an area of one ward for older children which was decorated accordingly. However, across the rest of the hospital, not many facilities were available for older children, especially in the day case ward, where older TVs did not allow them to use streaming services. The lead play specialist told us they had recently met with the new head of IT to discuss improving the provision for older children.

The hospital's international office managed all aspects of care for international patients throughout their pathway. The team was designed to meet the needs of the large number of international patients that used the service. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. On site Arabic interpreters were available Monday to Friday from 8am to 8pm. There was an out of hours service. The hospital was also signed up to a telephone interpretation service which was available 24 hours a day, seven days a week.

There was a multifaith room available for patients. A multi-faith chaplain was available 24 hours a day, seven days a week. Throughout 2021, only two children had died in the hospital and senior staff assured us this was an uncommon event. Evidence provided confirmed appropriate end of life discussions were held with these families and bereavement support was offered. However, there was no formal policy or procedure in place regarding provision for children at the end of life at the time of our inspection. Senior staff told us they were planning to introduce a paediatric mortality framework later in the year.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. We saw examples of patient menus with varied food options available.

## Access and flow

**People could access the service when they needed it and received the right care promptly.**

Good

# Services for children & young people

Between March 2021 and February 2022, there were 31084 consultations, 3002 day case procedures, 1142 inpatient episodes and 24443 outpatient appointments across the service. In the urgent care centre, only one patient was seen at a time, with a total of 168 patients seen in February 2022.

The hospital did not specifically collect waiting time audit data for elective surgery as children were able to be seen, assessed and admitted to the service in accordance with their personal circumstances. In the urgent care centre, children were seen by appointment only and the team demonstrated they met key performance indicators for these appointments. In the outpatient department, two clinics each month were randomly audited for waiting times. Patients were made aware of any delays in the waiting areas.

In the 12 months prior to our inspection, the hospital reported 16 procedures (0.4%) had been cancelled for a non-clinical reason. The reasons included theatre staff not being available (five), the surgeon having COVID-19 (two), patients did not attend (two) and personal reasons relating to the patient (two). When children and young people had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Daily bed meetings ensured there were sufficient beds and staff for expected admissions the following day and identified potential issues. Along with discharge planning meetings, this helped to prevent delayed discharges and staffing issues.

### Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Between February 2021 and January 2022, the children's service received 27 formal complaints. The majority of these related to communication, quality of care and consultants. Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers investigated and shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. This included standardising the approach to fractures in the urgent care department and ensuring call backs were completed for all patients in the day case ward.

The service was signed up to an independent review service for resolution of formal complaints, but no complaints had been escalated to them for review in the 12 months prior to inspection.

## Are Services for children & young people well-led?

Good

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

Good

# Services for children & young people

## 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 patients and staff. They supported staff to develop their skills and take on more senior roles.**

There was a clear organisational structure within children and young people's services which ensured clear lines of reporting and governance across all areas. Staff we spoke with were positive about both their immediate line managers and senior leaders and felt they were visible and approachable, and welcomed feedback about the service. Senior leaders attended the inductions of new staff and visited each department regularly, with informal weekly sessions held with the chief nurse. Leadership training was available for staff, and we were given numerous examples of internal promotion and development.

## 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. Leaders and staff understood and knew how to apply them and monitor progress.**

The hospital's aim was to 'be recognised as the number one hospital in the UK dedicated to the care of women and children'. Their 2021-24 strategy focused on four strands, namely exceptional care, people, operational excellence and clinical pathway development and quality. This included the redevelopment of the hospital, and although there had been some delays due to COVID-19, there were clear timelines to refurbish ward areas, create a new urgent care centre, develop a hybrid theatre and create a new wellbeing centre for staff and families. There was also focus on recruiting and retaining more staff and developing specialties such as complex spinal surgery for children. Leaders told us the vision and strategy had been developed with the engagement of staff. Staff we spoke to where aware of the future direction of the hospital.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

The majority of staff we spoke with were positive about the service and told us they were respected, supported, and valued. Although some staff described a period of adjustment when paediatric services had been moved from a sister hospital, most felt this had settled down and the two groups of staff now felt like one team. There were freedom to speak up champions within the service to support staff to raise concerns. Staff we spoke with were aware of the freedom to speak up champions and how to contact them.

A diversity and inclusion committee operated at provider level, with representatives from hospital. The chief executive officer had attended training on inclusive leadership, with a further day planned to develop a diversity and inclusion strategy. However, not all staff were aware of these developments. The hospital celebrated a number of celebrations from different religions and cultures throughout the calendar year.

Patients we spoke with during our inspection told us they felt able to raise any concerns with staff.

## Governance

**Leaders operated effective governance processes throughout the service. 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**.

Good

# Services for children & young people

The service had a clear governance structure which ensured information flowed from ward and service level to the monthly hospital board meeting. Chaired by a consultant paediatrician, the medical advisory committee (MAC) ensured all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake treatments they provided. Staff conducted a range of audits to assess clinical effectiveness. We saw audit results, along with patient outcome data, complaints and incidents were discussed and reviewed at relevant meetings.

### 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.**

The paediatric risk register fed into the hospital wide risk register and both were reviewed regularly. We reviewed the risk register and found risks were recorded with clear descriptions and controls in place identified, all risks had a risk rating score, a date for review and risk owner identified. Most of the risks we identified on inspection were on the risk register, with senior staff aware of issues such as reduced psychological support for inpatients and families and suboptimal staff facilities. There was a business continuity policy which detailed what to do in the case of unexpected emergencies.

### 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 secure but not fully integrated. Data or notifications were consistently submitted to external organisations as required.**

The service had a clinical dashboard which was shared with all staff and outlined key performance, risks, complaints, incidents and feedback. All policies were available for staff to access via the hospital intranet.

Patient information and records were stored securely on all the wards and in all departments we visited, but a mix of paper-based and different systems of electronic notes were used across the service. Some staff reported issues with accessing records and IT systems in general. Senior staff told us this was a focus for the hospital going forward, with integration into a unitary record as the eventual goal. The replacement of computers and improvement of Wi-Fi were the first step, with a new full-time IT manager for the hospital overseeing this project.

There were systems in place to ensure data and statutory notifications were submitted to external bodies, such as safeguarding notifications to local authorities. The registered manager was responsible for submitting statutory notifications to the CQC.

### Engagement

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

Patients were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the hospital website, social media and email. This feedback was shared with staff and used to drive improvement. Patient stories were collected and featured in patient information. Although some patient involvement had taken place virtually during COVID-19, the hospital wanted to start engaging with patients face-to-face again.

Good

# Services for children & young people

Staff were able to give feedback via the six-monthly staff engagement surveys. The results in October 2021 showed decline from the previous survey on most measures, with the majority of staff who responded (54%) saying they believed a greater focus on staffing and equipment was warranted. Staff told us feedback from these surveys had led to some improvements in staff facilities, although many of the areas were not large enough to accommodate all staff taking breaks.

There was a staff newsletter and a variety of reward schemes for recognising staff achievement. During COVID-19, a number of wellbeing initiatives had been established to support staff.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.**

Senior leaders took immediate action in response to issues identified during the course of this inspection visit. Staff were committed and passionate about improving the service they provided. However, not all staff were formally trained in quality improvement techniques.

During COVID-19, the hospital wrote and published three papers relating to screening techniques.