Chelsea and Westminster Hospital NHS Foundation Trust

West Middlesex University Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected
Are services safe?	Good
Are services well-led?	Good

Our findings

Overall summary of services at West Middlesex University Hospital

Not inspected

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at West Middlesex University Hospital.

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

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

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

We did not rate this hospital at this inspection. The previous rating of good remains.

We also inspected 1 other maternity service run by Chelsea and Westminster Hospital NHS Foundation Trust. Our reports are here:

- Chelsea and Westminster Hospital – https://www.cqc.org.uk/location/RQM01

How we carried out the inspection

During the inspection we spoke with 42 staff including the director of midwifery, head of midwifery, obstetricians, doctors and midwives. Attended handover meetings, reviewed 8 records and spoke with 4 women and families

We received 377 give feedback on care forms through our website of which 136 were positive, 144 were negative and 97 were mixed.

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

Maternity

Outstanding ☆ ➔➔

Maternity services at West Middlesex Hospital, West London, include antenatal, intrapartum (care during labour and delivery) and postnatal maternity care.

The maternity unit includes an obstetric consultant-led delivery suite, maternity triage, and wards for antenatal and postnatal care. The alongside midwifery-led birth centre provides intrapartum care for women and birthing people who met the criteria and are assessed to have lower risk pregnancies. The birth centre has 4 birthing rooms, two of which have birth pools and ensuite facilities. In the calendar year 2022 there were 4440 at West Middlesex Hospital of which 488 (10%) of births were at the alongside midwifery led unit (birth centre) and 84 (1.7%) were home births Our rating of this service stayed the same. We rated it as outstanding because:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, 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 and learned lessons from them.
- 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. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

Is the service 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.

Midwifery staff received and kept up to date with their mandatory training. Data showed 82% of midwifery staff were compliant with completion of mandatory training. This did not meet the trust target of 90%.

Medical staff received and kept up to date with their mandatory training. Data showed medical staff were 94% compliant with completion of mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Maternity

The mandatory training was comprehensive and met the needs of women and staff. Staff completed multi-disciplinary obstetric and midwifery simulation 'MoMs training once a year. Data showed as of February 2023, 96% of staff across the trust had completed yearly MoMs training and 90% of staff had completed neonatal or advanced life support training. As of January 2023, 90% of midwives across the trust had completed fetal monitoring training.

Staff completed regular skills and drills training. For example, staff had recently completed pool evacuation, postnatal collapse and responding to baby abduction drills. Managers recorded these drills so the videos could be shared with staff unable to attend.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, compliance with safeguarding adults and children level 3 training for midwives needed to improve.

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with, had completed online safeguarding training in the past year. As of February 2023, 100% of midwifery staff working at West Middlesex Hospital had completed safeguarding adults' level and level 2 and safeguarding children level 1 and 2. However, midwifery staff compliance with safeguarding adults level 3 was 67% and 61% for safeguarding children level 3. The trust had plans to improve safeguarding training compliance by the end of June2023.

For medical staff safeguarding training compliance was consistently above 90% for safeguarding adults' level 1, 2 and 3 and safeguarding children level 1 and 2.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding team which was made up of safeguarding specialist midwives and perinatal mental health midwives who oversaw the care of vulnerable women and birthing people having babies at West Middlesex Hospital.

We saw that a representative from the safeguarding team attended multidisciplinary ward rounds on labour ward.

At the time of inspection the 'River' team provided a continuity of carer service for families with moderate to high risk safeguarding needs. The team was set up in August 2022 to provide a more individualised service and to improve liaison with external agencies such as the community perinatal mental health team and independent domestic violence advocates.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, 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.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Data showed hand hygiene audits were completed every month in all maternity areas. Between October and December 2022 compliance for hand hygiene audits was consistently above 95%. Managers completed PPE audits across all maternity areas. Between October and December 2022 performance was consistently above 95% except for one occasion on labour ward in December 2022 where compliance was 90%.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use. However, on the birth centre the cleaning of the pools was not formally recorded, and the staff did not have access to records of legionella checks.

Leaders monitored rates of sepsis infections in labour and postnatally. Between July and December 2022, there were 2 incidents of sepsis in labour and 4 incidents of sepsis in the postnatal period.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure. There was a monitored buzzer entry system to the maternity unit and the reception area was staffed 24 hours a day, 7 days a week. The service had two maternity theatres and three high dependency beds for women and birthing people requiring a higher level of monitoring after delivery.

Women and birthing people could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. Records of the last three months resuscitaire checklists showed resuscitaires were checked at every shift on labour ward.

The service had suitable facilities to meet the needs of women and birthing people's families. For example, on the alongside midwifery-led unit women and birthing people had access to birthing pools, birth balls and stools to support movement in labour.

The service had enough suitable equipment to help them to safely care for women, birthing people and their babies. The service kept an equipment register, which showed all medical devices were in date for servicing.

Staff disposed of clinical waste safely and sharps bins were labelled correctly.

Following the inspection we raised concerns about the security and dignity of the management of the baby in the bereavement suite. The trust took immediate action to improve the bereavement pathway by updating the bereavement care policy and communicating this with the maternity department. The trust also told us following the inspection the had further plans to improve the bereavement suite by the end of May 2023.

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 and birthing people at risk of deterioration

Maternity

Staff used an evidence-based, standardised risk assessment tool for maternity triage. This tool rates the urgency of obstetric review needed from red, the most urgent (immediate transfer to labour ward and obstetric review) to green the least urgent (junior obstetric review needed in 4 hours).

Women and birthing people in maternity triage were seen in a timely way. Triage audits showed between October and December 2022 initial assessment by a midwife within 15 minutes, was achieved 91 – 94% of the time.

Managers monitored the timeliness of the response to triage phone calls. Data showed triage calls were answered in a timely way most of the time. Data for October to December 2022 showed 81-92% of calls were answered and 4-5% of calls were abandoned. The average time to answer was between 25 and 44 seconds.

Staff used a nationally recognised tool to identify people at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS). The use of MEOWS was taught in the multidisciplinary emergency skills training day.

However, audit data showed staff did not always fully compete MEOWS charts. The December 2022 MEOWS audit showed 39% recorded urine output. January 2023 audit showed 40% of MEOWS charts were scored but not fully completed.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle.

Staff risk assessed women and birthing people continually antenatally and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

Staff knew about and dealt with any specific risk issues. For example, staff used a ‘fresh eyes’ approach to ensure fetal monitoring was carried out safely and effectively. Managers audited compliance with women and birthing people having continuous CTG monitoring during labour. Data for the September 2022 audit showed there was appropriate interpretation and management plans following CTG in 19 out of 20 cases and ‘fresh eyes’ were completed at each hourly assessment in 19 out of cases 20.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of deteriorating mental health during pregnancy. Staff screened women and birthing people for depression using a specific questionnaire referred to as the ‘Whooley questions.’

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. Managers monitored the effective use of handover of care and the SBAR tool. Managers told us they monitored the use of SBAR tool and quality and effectiveness of handovers however the results were not shared with CQC.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed between November 2022 and January 2023 compliance was consistently 100%.

Maternity

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a consultant midwife to discuss risks and options available to create a suitable birth plan together. In addition to this the pregnant women or person would have an appointment with a consultant obstetrician before making their final decision about labour and birth. Birth plans were shared with the multidisciplinary team.

The service had provision for up to 30 transitional care beds for babies needing additional observation.

Shift changes and handovers included all necessary key information to keep women, birthing people and babies safe.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people 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 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.

Most of the time, the service had enough nursing and midwifery staff to keep women, birthing people and babies safe. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Data showed 47 red flag incidents reported between 1 November 2022 and 31 January 2023. The most common red flag incidents were delays in providing pain relief (51% of reported red flags) and the labour ward coordinator being unable to maintain supernumerary status (23% of reported red flags). Managers reviewed all red flags, monthly and none of the reported red flag incidents breached the NHS Resolution definition of loss of supernumerary status.

Midwifery staffing levels impacted on the sustainability of the birth centre service. Due to staffing challenges, birth centre staff were re-deployed to the labour ward on 66 occasions between 1 November 2022 and 31 January 2023.

Maternity triage was open 24 hours a day, 7 days a week and the planned staffing was 2 midwives and a maternity support worker. At the time of inspection there was one midwife in triage, but activity levels were low, so this did not impact on care. Staff could escalate to the matron of the day to if activity levels increased, and another midwife was needed. Telephone triage was staffed by midwives working from home, so these staff were protected from being pulled into the numbers on labour ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders completed a maternity safe staffing workforce review in line with national guidance in May 2021 and presented a business case to board in December 2022. This review recommended 234.96WTE midwives' band 3 to 8 were needed against the current funded staffing of 196.24 WTE, a shortfall of 38.62 WTE staff on the West Middlesex site. The trust board agreed the maternity workforce business case for phase 1 and 2 in January 2023.

The ward manager could adjust staffing levels daily according to the needs of women and birthing people. The service had a daily staffing situation report meeting at 09:15 attended by the head of midwifery and matrons from across the trust. The service had a 'matron of the day' who was available to support clinically if needed.

Maternity

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and birthing people accessing the service. The matron of the day completed the staffing acuity tool every 4 hours. The service used a traffic light red, amber, green system to determine the capacity of the unit. Green status meant the unit was functioning at normal capacity, amber status meant there were insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and red status would lead to a decision to close the unit. The unit leader updated the traffic light status 4 times during a 24-hour period.

The service had reducing vacancy rates. There were 26 WTE midwifery vacancies at the time of inspection. The trust held a recruitment day in December 2022 for maternity staff. Leaders had started work on international European recruitment for staff from Greece, Italy and Spain.

The service had low turnover rates.

The service had reducing sickness rates. The sickness rate was 10% at the time of inspection.

The service had low rates of bank and agency midwifery staff usage. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 76% of maternity staff had received a yearly appraisal as of February 2023.

Managers made sure staff received any specialist training for their role. For example, staff had access to additional training including but not limited to, advanced cardiotocography (CTG) training, perinatal mental health training, research methods and neonatal life support.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment. However, medical cover of triage was not always sufficient.

The service had enough medical staff to keep women, birthing people and babies safe on labour ward. The service prioritised medical staffing on the labour ward to keep women, birthing people and babies safe. The labour ward had 98-hour consultant obstetrician cover on site with twice daily consultant led ward rounds on labour ward. This was in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 4000 to 5000 births a year

The service always had a consultant on call during evenings and weekends and resident obstetric consultant cover overnight. The service had 21consultants, 1 obstetric medicine out of hours consultant, 10 who covered a resident on-call rota and 10 of which were on a non-resident on call rota.

Maternity

Medical cover of triage was not always sufficient. Data from October to December 2022 triage audits showed there were sometimes delays reviewing women and birthing people on orange triage pathways ST3 – ST7 – 55 – 73% of the time. Women and birthing people on a green or yellow triage pathway were seen by a doctor within the agreed time frame 100% of the time. Staff we spoke with told us performance had improved as since December 2022 triage had a dedicated registrar between 2pm and 5pm Monday to Friday.

Records

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

Notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records.

We reviewed 8 records on inspection and found records were clear and completed.

The trust had plans to transition to fully electronic records by September 2023.

Managers audited 20 maternity records every month. The January 2023 records audit showed most antenatal risk assessments such as COVID-19, venous thromboembolism (VTE) and aspirin assessment were completed, but there were two instances out of 20 records where the booking risk assessment was not recorded.

Records were stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. However, on the birth centre we found two boxes of an antibiotic medicine that went out of date a month ago.

There was a recorded risk on the risk register in relation to the risk of unauthorised prescribing of patient group directive (PGD) medicines on the electronic records system. The risk was mitigated by the practice development midwife having oversight of PGDs on a spreadsheet.

Staff reviewed each woman's medicines regularly and provided advice to women and and birthing people about their medicines. Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed were clear and up to date.

Staff had access to medicines used to respond to emergencies safely. On delivery suite, staff had access to emergency 'grab boxes' to respond to conditions such as pre-eclampsia, sepsis and cord prolapse.

The service noted at the divisional quality meeting, there was an increase in medicine error incidents in December 2022 and planned to set up a task group to improve medication safety in maternity.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women 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 trust policy.

The service across both sites had reported one retained swab 'never event' in 2018 and this remained on the risk register however, there had been no repeat of this since. The risk was mitigated by addition of swab counting trays on delivery trolleys, ensuring robust documentation processes, and removal of smaller sized swabs from being stocked on the unit and in delivery packs. Managers shared learning about never events with their staff and across the trust.

Staff reported serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women, birthing people and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning from incidents in the monthly maternity quality and audit newsletter. The January 2022 newsletter showed the top reported incidents were term admissions to the special care baby unit, post-partum haemorrhage and maternal readmissions. Learning from serious incidents was also shared in this newsletter. For example, feedback from a HSIB report that recommended involvement of the multidisciplinary team before and during an assisted vaginal birth and if an emergency arises.

Staff met to discuss the feedback and look at improvements to the care of women. Managers attended a weekly maternity quality audit and safety (MQAS) meeting at the West Middlesex site and once a month this weekly meeting was a cross-site meeting with Chelsea and Westminster Hospital.

Managers investigated incidents. We reviewed the last 3 serious incident 72-hour investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified.

Managers debriefed and supported staff after any serious incident. The service had improved the debriefing process as part of a quality improvement project to include hot debriefs immediately after the event, cold debriefs within two weeks and a formal debrief with the psychology team.

Is the service well-led?

Good ➔➔

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

Leadership

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

Maternity

Maternity services at West Middlesex University Hospital were managed as part of the Women's Services division. The Women's Services division across the trust was managed by a divisional director of midwifery & nursing. At West Middlesex University Hospital services were managed by a deputy director of midwifery supported by six matrons, of which one matron post was out to advert at the time of inspection.

We observed on inspection and staff told us that senior managers were visible and available. The completed daily walk-rounds of the maternity unit and attended multidisciplinary safety huddles.

Matrons often worked clinically on the delivery suite to ensure staff could take breaks.

The director of midwifery met with the board maternity safety champion every six weeks. The Deputy Director of Midwifery, Clinical Director, neonatal lead, anaesthetic lead and maternity voices chairs also attended this meeting. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

Information on the maternity safety champions was displayed in the maternity unit.

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.

Women's services had a clear vision and strategy. The 2021 – 2024 strategy was focused on three priorities: provide high quality care, be effective and efficient, be the employer of choice.

At the time of inspection the service was about to start developing the new strategy for the next five years and service leaders told us they planned to conduct engagement with staff and stakeholders to develop this in a co-operative way to best meet the needs of service users and staff.

Culture

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

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women's concerns about their care in a less formal way.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified theme. In the six months before the inspection, there was only one formal complaint reported to the hospital and this was investigated and responded to in line with the trust policy.

Leaders had a strong focus on staff wellbeing and managers ensured staff got their breaks. The service had a staff recognition scheme called the 'cheer' awards.

Staff we spoke with were consistently positive about working at the hospital and told us they felt well supported and able to raise concerns when needed and were part of an inclusive culture. The service had a maternity equality, diversity and inclusion statement. This was displayed throughout the maternity unit. Two midwives from across the trust were enrolled on the Capital Midwife Fellowship scheme. The service was implementing the anti-racism framework and working towards the bronze level award.

The service had 12 maternity cultural safety champions. The purpose of the cultural safety champions was to address inequalities and improve equity for staff and people using services with protected characteristics. The champions delivered cultural safety training as part of yearly mandatory training. The two hour long cultural competency training sessions aimed to encourage staff to reflect on unconscious biases, understand existing inequalities in maternal and neonatal outcomes and consider how staff can improve their practice to reduce inequalities.

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.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. There were: women's services directorate board meeting every month, trust wide senior midwives meeting every month and a maternity forum every month for West Middlesex Hospital site.

We reviewed minutes of the last 3 women's services directorate board meetings attended by the director of midwifery, general manager for women's services and the clinical director. A standard agenda was used to discuss external visits, risk management, patient experience, and workforce.

We reviewed minutes of the last 3 monthly maternity forum meetings. These meetings were chaired by the consultant obstetrician and attended by a range of midwifery and medical staff. A standard agenda was used to discuss external and internal learning presentations, research, anaesthetic update, incidents and audit, clinical guidelines, education and infection control.

We reviewed two examples of the labour ward coordinators meeting minutes. Labour ward coordinators met every two weeks to discuss management of the day assessment unit and triage, staffing, recruitment and delays to induction of labour.

The service had a weekly Perinatal Mortality Review tool (PRMIT) meeting that was attended by the audit midwife, PMRT midwife and consultant obstetrician. There was an ongoing action log to drive improvement. However, actions sometimes appeared slow-paced. The service collected trust-wide PMRT data and presented case reviews and findings to the trust board. Cases were examined in a comprehensive way and actively sought out parents' perspective and experience of their care to drive system-wide improvement.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies including the birth centre standard operating procedure and the triage operating procedure. These were in line with national guidance. At the time of inspection there was one guideline due to expire in the next three months and 20 guidelines due to expire in the next 6 months. The service had a guidelines quality improvement midwife in post and an action tracker to ensure guidelines were updated in a timely way.

Management of risk, issues and performance

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

At West Middlesex hospital, the top recorded risks included: the inability to adequately meet fetal medicine screening targets, maternity emergency call be system and nitrous oxide exposure. These risks were mitigated by the existing fetal medicine screening team working additional hours, use of phones which were available in all rooms to call 2222 and improving ventilation in the two rooms staff exposure to nitrous oxide was high.

Top risks across maternity services at the West Middlesex site and the Chelsea and Westminster site, were safe midwifery staffing, ongoing challenges to delayed induction of labour, and challenges to maintain the birth centre service. These risks were mitigated by agreement being secured from trust board to invest in additional midwifery staffing, ongoing audit and early escalation of delayed induction of labour and ongoing recruitment to improve the sustainability of the birth centre.

Managers carried out a comprehensive programme of repeated audits to check improvement over time. The service had a yearly audit programme and participated in relevant national clinical audits. For example, the service participated in the national maternity and perinatal audit and the national diabetes in pregnancy audit. The service collected data on 3rd and 4th degree tears, also known as an obstetric anal sphincter injury (OASI) and held an OASI clinic to follow up on women who have experienced this type of trauma. Leaders reviewed performance in audits at divisional meetings.

The maternity dashboard showed did not compare outcomes to national averages or national standards. Data showed in the last 12 months December 2021 to November 2022 there 20 stillbirths out of 4,911 births. This was in line with the national average of 4.1 were stillbirths for every 1,000 births. Data showed in the last 12 months December 2021 to November 2022 132 avoidable term admissions to the neonatal unit, 85 women had a 3rd or 4th degree perineal tear and 232 had a post-partum haemorrhage of over 1500ml.

Managers shared and made sure staff understood information from the audits. The audit team created and shared a newsletter to staff every with learning from audits

The service was accredited by the UNICEF Baby-friendly initiative.

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at board level. The last Ockenden review update to the board level safety champions showed the trust was compliant with all 7 immediate essential action and twelve clinical priorities from the 2020 Ockenden report.

The service was accredited by the clinical negligence scheme for trusts, now called the maternity improvement scheme. Recent audits showed the service met all 10 safety standards and the service had met these standards for the past three years also.

Maternity

Following the inspection we raised concerns about the risk assessment of access to neonatal resuscitation equipment on the birth centre. The trust took immediate action to improve the risk assessment and write a business case for additional neonatal resuscitation equipment.

Leaders worked across the local maternity and neonatal system to improve services. For example, they worked together on Ockenden recommendations and the Maternal and Neonatal Safety Improvement Programme.

The Director of Midwifery chaired a European Union Recruitment task and finish group in January 2023, so trusts could work collaboratively to attract midwifery staff.

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 multiple paper and electronic records systems used at the time of inspection was a recorded risk. This was a recorded risk since 2016. The risk was mitigated by the service having a fully funded digital maternity transformation project in progress. The service was in the process of moving to a new end to end electronic records system in February 2023, to be completed by September 2023.

Engagement

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

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity voices partnership (MVP).

The service had strong links with the local MVP, and they were involved in the governance of the service. The MVP had co-produced a 'Muslim Mums memo card' that outlined rituals and aspects of care that were important to them. In addition the MVP had co-produced an information booklet on induction of labour and a decision aid tool for induction.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, the trust scored 'better' or 'somewhat better than expected' for 7 questions and 'about the same as expected' for 44 questions.

The 2022 General Medical Council National Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

The board safety champion ran open forums both virtual and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.

The trust had worked in partnership with trusts in North West London to develop the maternity trauma and loss care service. The service was developed with input from women and families who had faced maternity trauma and loss. The multidisciplinary team of specialist midwives and psychological practitioners supported women with a severe fear of childbirth and people who had a previous traumatic birth or experience of baby loss. The service won the National Positive Practice in Mental Health Award in 2022 for the perinatal and maternal mental health category.

Maternity

Learning, continuous improvement and innovation

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

The service had an active reproductive health and childbirth research team. The service was part of a national research trials including but not limited to: the Babies and Mum Samples Study (BaMSS) study which aims to answer the question 'what is the best way to take a sample to sequence a baby's genome?' and the Giant Panda study which aims to find out which is the best medication (labetalol or nifedipine) to treat high blood pressure in pregnant women. Across the trust in the calendar year 2022, the research team successfully recruited 3210 participants to 24 open studies.

Staff were supported to complete quality improvement projects. For example, the service had taken a quality improvement approach to improve the debriefing process with a focus on staff psychological safety. The formal debrief process included a hot debrief five minutes after an incident, a cold debrief within two weeks of the incident using a structured after-action review approach and finally a debrief facilitated by the psychology team.

Outstanding practice

We found the following outstanding practice:

- Maternity services had improved the way it worked with local communities. The maternity voices partnership (MVP) had co-produced a Muslim Mums Memo card with local Muslim women.
- Maternity services had a strong focus on reducing workforce inequalities and inequalities experienced by women and birthing people using the service. Part of this work included developing 12 staff as maternity cultural safety champions. The purpose of the cultural safety champions was to address inequalities and improve equity for staff and people using services with protected characteristics. The champions delivered cultural safety training as part of yearly mandatory training.
- The service was awarded the National Positive Practice in Mental Health winner for 2022 in perinatal and maternal mental health for its Maternal Trauma and Loss Care (M-TLC) service which offers joined up psychological specialist support with maternity services to treat and prevent trauma associated with childbirth.
- The service was shortlisted for its work in continuing to adapt and improve services in the 'excellence during a global pandemic' award, including use of private ambulance services to secure the homebirth service, swift adaptation of services using technology and redeployment, and developing an antenatal vaccination centre.
- The service had a strong focus on staff wellbeing and utilised a number of initiatives to maintain and improve this, including staff recognition schemes, award nomination, career clinics and emotional wellbeing support.

Areas for improvement

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

Action the trust SHOULD take to improve:

Maternity

West Middlesex University Hospital

- The service should ensure midwifery staff are up to date with mandatory training modules. (Regulation 12 (2) (c))
- The service should ensure midwifery staff are up to date with safeguarding adults and children level 3 training. (Regulation 12 (2) (c))
- The service should ensure staff have a yearly appraisal. (Regulation 12 (2) (c))
- The service should ensure that babies in the bereavement suite are stored in a secure and dignified way (Regulation 10 (1))
- The service should ensure compliance with MEOWS audits improves. (Regulation 17 (2) (a))
- The service should ensure that there is an improved risk assessment of access to neonatal resuscitation equipment on the Birth Centre. (Regulation 17 (2) (b))
- The trust should ensure medical cover for triage is sufficient. (Regulation 18)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors, 2 midwifery specialist advisors and an obstetrician specialist advisor.

The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.