Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster Hospital

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good
Are services well-led?	Good

Our findings

Overall summary of services at Chelsea and Westminster Hospital

Outstanding ☆ ➔➔

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 Chelsea and Westminster Hospital.

We inspected the maternity service Chelsea and Westminster 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, focussed 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 report is here:

- West Middlesex Hospital – https://www.cqc.org.uk/location/RQM91

How we carried out the inspection

We inspected the service using a site visit where we observed care on the wards, spoke with staff, managers and service users, and attended meetings. We interviewed leaders and members of the executive team remotely after the site visit. We looked at online feedback from staff and service users submitted via the CQC enquiries process. The service submitted data and evidence of their performance after the inspection which was analysed and reviewed for use in the report.

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

Maternity

Good ➔➔

Maternity services at Chelsea and Westminster Hospital, West London, include antenatal, intrapartum (care during labour and birth) and postnatal maternity care.

The maternity unit included a consultant-led labour ward, maternity triage, and wards for antenatal and postnatal care. The alongside midwifery-led birth centre provided intrapartum care for women and birthing people who met the criteria and are assessed to have lower risk pregnancies. There was a private maternity wing for patients wishing to pay for their care, located adjacent to both the midwife led unit and obstetric consultant led labour ward.. The birth centre has 6 birthing rooms, 4 of which have birth pools. Between December 2021 and November 2022 there were 5346 babies born at Chelsea and Westminster Hospital. In the 12 months preceding the inspection, 10.6% of births were at the alongside midwifery led unit (birth centre). The home birth rate was 0.9%. There were 850 births in the private wing during the 2022-23 financial year.

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

- The service had enough staff to care for women and birthing people and keep them safe. Staff had training in key skills, and worked well together for the benefit of women and birthing people, understood how to protect them from abuse, and managed safety well. The service mostly controlled infection risk 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 and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to continuous service improvement and enjoyed coming to work.

However:

- The service used several different systems to document care which was time-consuming for staff and there were discrepancies in recording between different systems. Telephone advice given in triage was documented on paper but not routinely contemporaneously added to the electronic record, which led to incorrect timelines of care and staff not always having accurate up to date information available. Managers have taken steps to mitigate this since the inspection by allocating more staff, and the implementation of a new end-to-end IT system had begun.

- Some levels of compliance did not meet the trust targets including but not limited to correct completion of observations charts, some screening tests, daily equipment checks, and staff annual appraisals.

Is the service safe?

Requires Improvement ➔➔

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

Maternity

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 86% of midwifery staff and 80% of medical staff were compliant with overall completion of mandatory training, however these figures were below the service target compliance rate of 90%. Some modules of mandatory training had lower compliance rates, particularly basic life support, fire, and moving and handling modules. Since the inspection the trust provided data to show an increase in mandatory training to 91% and 87% and told us they would be compliant by May 2023.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Staff completed multi-professional obstetric emergency training once a year. Data showed as of February 2023, 96% of staff across the trust had completed the yearly training. The service had large clinical training facilities making use of modern technology to aid learning. Skills and drills were completed regularly. Training had a focus on human factors and provided staff with the opportunity for self-reflection and peer review. Staff evaluation on their training sessions was positive. Staff had recently completed pool evacuation, postnatal collapse and sepsis training.

As of January 2023, 90% of midwives and 95% consultants across the trust had completed fetal monitoring training.

Staff completed newborn life support training, 100% of community midwifery staff and 98% of hospital-based midwifery staff had attended the training from Chelsea and Westminster Hospital.

New staff were given a supernumerary period, and international staff were supported with relevant skills training. Clinical staff completed competency assessments. Staff we spoke to said they felt supported during their induction period, but the supernumerary period was short in some areas and would benefit from an increase. The trust had increased the supernumerary period in November 2022 in response to staff feedback, preceptorship midwives have a supernumerary period of 75 hours initially and 37.5 hours at the start of each new rotation.

The service also kept and encouraged staff to complete records of continuing professional development (CPD) training, which is external to mandatory training requirements.

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.

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 and maternity support staff working at Chelsea and Westminster Hospital had completed safeguarding training to a level appropriate to their role. However, some specialist midwives were overdue their training.

Medical staff had lower rates of compliance with safeguarding training. Data supplied by the service showed that 50% of obstetric medical staff had completed level 3 adult safeguarding training, and 81% had completed level 2 child safeguarding training. Since the inspection, the trust provided evidence to show an improvement in these figures.

Maternity

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 socially complex women and birthing people having babies at Chelsea and Westminster Hospital.

Women and birthing people from socially complex groups were prioritised for continuity of carer midwifery teams.

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

There was a safeguarding lead midwife for the service supported by a senior midwife. Safeguarding specialists supported maternity staff to provide appropriate care for women and families with safeguarding concerns, and report on safeguarding work to local commissioners annually. The service worked with 2 independent domestic abuse advocates at Chelsea and Westminster Hospital.

Staff liaised with other agencies to co-ordinate care and kept clear records. A tool was being piloted to assist staff to appropriately risk assess safeguarding cases.

Cleanliness, infection control and hygiene

The service mostly 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.

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 mostly above 95%. Managers completed PPE audits across all maternity areas. Data showed that PPE compliance was above the trust target rate in all maternity wards except the maternity inpatients department. This department consistently failed PPE audits with compliance results between 60-80%. Since the inspection, the trust provided March 2023 PPE audit results showing all areas scored 100%.

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. Cleaning of the pools was recorded, and staff had access to records of *Legionella* checks.

Leaders monitored rates of sepsis infections in labour and postnatally. Between July and December 2022, there were 16 incidents where sepsis was a factor.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, daily checks on equipment were not always completed.

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 five high dependency unit beds.

Maternity

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

Staff mostly carried out daily safety checks of specialist equipment. Labour ward records of the last three months shows resuscitaires were checked at every shift. However, there were some instances when not all equipment had been checked daily, including some emergency trolleys. Resuscitaires in the birth centre were audited for daily checks and compliance was improving during the 3 months prior to inspection. The most recent compliance rate for birth centre resuscitaires daily checks was 99%. In the Kensington private wing, resuscitaire daily checking compliance was consistently below target; data from October to December 2022 showed that daily checks had taken place 42 – 64% of the time. On the day of inspection, we found that some equipment on the Kensington Wing resuscitaires was dusty, out of date, and that daily checks had not been taking place regularly. We also found poor compliance with daily checking in the Simpson Unit (high dependency recovery area). This was escalated to staff immediately, and we fed back to senior leaders about poor compliance with daily checks in this high-risk area. Since the inspection, the trust provided data from audits showing improvement in daily checking and was compliant in 3 out of 4 checklists on Kensington Wing and Simpson Unit in March 2023.

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. There were 2 bereavement rooms located close to the labour ward that offered families the opportunity to stay together following the birth of their baby. The rooms had all the recommended facilities according to national guidance however, the service recognised that the rooms appeared clinical and had a plan in place to improve accommodation to feel more homely.

Staff told us that they would like to see decoration on the wards improved for women and birthing people using the service and that at times the environment was too small for the number of women and birthing people receiving care.

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

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

The service monitored exposure to medical gases used as pain relief in labour (nitrous oxide) and reviewed this as part of their trust risk-register.

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.

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 within 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 77 – 95% of the time. Triage audits were comprehensive and detailed; reasons for any delays were monitored by the service and mitigation was put in place to improve emergent risks. Results from triage audit and shared learning points were disseminated monthly to staff.

Maternity

Managers monitored basic information regarding triage phone calls including the number of calls answered and abandoned, and the time spent on the phone. However, staff told us that the phone system sometimes created additional pressure as calls for other departments were sometimes automatically diverted to them. The service told us that a new telephony system was due for installation in 2023 as part of triage service improvements, including new clinical rooms, separation from the day assessment service (planned appointments and pre-operative assessments) and dedicated call handlers.

The service had responded to patient needs and created a weekday ultrasound clinic within the triage setting where women and birthing people had timely access to urgent scanning as a part of the Saving Babies Lives Care Bundle v2 (2019). The clinic was led by a clinical fellow (a qualified doctor who was completing training in a specific field of medicine) which allowed women and birthing people to have their scan, results interpretation, and counselling in one combined appointment. Feedback from women and birthing people using this service had been positive and staff that we spoke to told us that this was a service improvement they were proud to offer. The service was evaluating ways to expand this service.

Staff used a nationally recognised tool to identify women and birthing 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 correctly or consistently complete MEOWS charts. The MEOWS audits between September and December 2022 showed charts were completed and scored correctly 60-85% of the time. Women were escalated to the appropriate clinician in 90-100% of cases. We reviewed incidents where MEOWS was a factor and found 4 out of 20 cases where inaccurately completed MEOWS charts could have contributed to missed opportunities in care across both sites in the trust.

Staff completed monitoring and risk assessment as part of the Saving Babies Lives v2 (2019) care bundle, and compliance against the care bundle was monitored and managed by the service. There was poor compliance with carbon monoxide monitoring in the notes we reviewed during inspection, 12 out of 17 had not had the recommended minimum testing. However, data from internal audits supplied by the trust showed compliance rates of 83% which met the trust target. The service performed well in all other areas of the care bundle and had low rates of babies born with brain injury at term.

There were clear criteria for use of the midwifery-led birth centre according to antenatal and labour risk assessments. The service also had clear criteria for use of the birth pool.

Staff knew about and dealt with any specific risk issues. For example, Data for the September 2022 audit showed there was appropriate interpretation and management plans following CTG and hourly ‘fresh eyes’ were completed in 18 out of 20 cases. However, during our records review we found that paper CTG traces were not always documented according to national recommendations. Most of the CTG traces used at Chelsea and Westminster Hospital were electronic and were documented appropriately. Staff used a sepsis screening tool and used Sepsis Six pathway to treat any cases of suspected sepsis in line with national guidance.

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 the ‘Whooley questions’.

Maternity

Staff shared key information to keep women, birthing people, and babies 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. There was a handover of care guideline which documented the service expectations. Managers monitored the use of SBAR tool and quality and effectiveness of handovers however audits showed 50% compliance with the use of SBAR and the practice was not yet fully embedded.

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%.

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. Prior to making their decision, women and birthing people have a consultant appointment and the final plans were shared with the senior MDT.

The service had 32 postnatal beds. These were used as flexible transitional care cots to manage and meet the needs of babies requiring additional observation before going home.

Midwifery Staffing

The service mostly 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 and birthing people and babies safe. The service told us that maternity 'red flags' were reported and monitored however, we did not see the data collected for Chelsea and Westminster Hospital. A red flag is a sign that there may be a problem with maternity staffing levels, such as delays in induction of labour, delays in administering pain relief and the service being unable to provide one to one care during labour.

In the 12 months preceding the inspection the maternity unit at Chelsea and Westminster Hospital had closed 4 times due to staffing pressures.

Midwifery staffing levels impacted on the sustainability of the birth centre service, and staff told us the birth centre would help to staff the labour ward in times of escalation. Staff told us women and birthing people would receive low-risk care on the labour ward if the birth centre needed to close.

Maternity triage was open 24 hours a day, 7 days a week and the planned staffing was 2 midwives and a maternity support worker. Staff could escalate to the maternity 'bleep holder' if activity levels increased and another midwife was needed. Midwifery staff in triage and across all areas of the maternity unit told us that more administrative, maternity support worker, and nursing support would alleviate staffing pressures when numbers of midwives were lower.

Maternity

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers and nursing staff needed for each shift in accordance with national guidance.

The service had reducing vacancy rates. Leaders completed a maternity safe staffing workforce review in line with national guidance in May 2021. There were 7.01 WTE midwifery vacancies and further temporary vacancies due to maternity leave and career breaks at the time of inspection. However, the workforce review recommended the service required a further 32 midwives. Service leaders presented a maternity workforce business case to the trust board in December 2022, of which phase 1 and 2 was agreed in January 2023.

The service held a recruitment day in January 2023 and discussed recruitment initiatives at their cross-site leaders' meetings with West Middlesex Hospital. Leaders had a project plan for international recruitment.

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, birthing people and babies accessing the service. The 'bleep holder' completed the staffing acuity tool and managers monitored staffing status. The service used a traffic light red, amber, green system to determine the capacity of the unit. Green status means the unit is functioning at normal capacity, amber status means there are 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. Data showed that between December 2022 and January 2023, staffing was rated as green 80% of the time, amber 19% of the time and there was 1 instance where the service had been rated red for safe staffing.

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 9.15 am attended by the Head of Midwifery and Matrons from across the trust. There was a maternity safety huddle meeting daily at 12.30 pm attended by the lead obstetrician on-call, labour ward co-ordinator and shift leaders on the maternity unit. The maternity bleep holder evaluated staffing and acuity at least every 12 hours, and more frequently in times of escalation according to trust policy. Matrons and specialist midwives worked clinical shifts as a part of their job role and could support clinical work whenever required.

The service had high turnover rates and attributed this to the central London location. However, after the inspection the service told us that turnover rates were below the trust target.

The service had low sickness rates. The sickness rate was 5.6% in December 2022, the national average rate of NHS sickness was 6.7%.

The service had a heavy reliance on their staff doing additional bank shifts, and agency midwifery staff. This was recognised by the service as a risk. Managers requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. We saw temporary staff induction and competency documentation that assured the service staff were safe. Agency staff were invited to attend training days at Chelsea and Westminster Hospital.

The service had a current maternity support worker vacancy of 6 whole-time equivalent posts. However, there was a full complement of administrative staff and nursery nurses. The service also used general nurses to support operative and high-dependency care requirements.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 85% of maternity staff had received a yearly appraisal as of February 2023. Since the inspection the trust provided data to show staff appraisal rates had improved and aimed to be compliant by May 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.

The service employed several specialist midwives including bereavement, fetal medicine, practice development, risk, quality improvement and others. The service had recognised where their population demographic may require special consideration and also had a specialist midwife for infectious diseases, and a cultural safety team, which has been commented on elsewhere in the report.

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.

The service had enough medical staff to keep women, birthing people and babies safe. The service prioritised medical staffing on the labour ward. The service had 30 consultants. 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. There was a dedicated obstetric on call consultant on-site from 8am until 10pm every day, and consultants provided night-time on call cover from home between 10pm and 8am.

The service used locum doctors to ensure safe levels of staffing when substantive staff members were unavailable. Locum doctors used by the service were substantive members of staff already working in the trust and were familiar with the service. Between October and December 2022, there were 215 times when locums had been used and managers monitored this.

Data from the General Medical Council National Trainee Survey (GMC NTS) Survey 2022 showed that junior doctors were spending disproportionate amounts of time in triage whilst their senior colleagues supported work on the labour ward. Doctors at both levels expressed concern around skill mix and learning opportunities as they were busy in their allocated areas. The service had acknowledged this, held listening events with doctors, and conducted a review to resolve issues. The service worked with Health Education England to monitor and improve, including introduction of additional staff, reduction in on call duties, better communication and integration between triage and labour ward, as well as a number of other improvement strategies.

Records

Staff did not always document care and advice contemporaneously. Staff kept detailed records of women and birthing people's care and treatment. Records were mostly up-to-date, stored securely and available to staff providing care.

The service used a paper records system for women and birthing people calling and attending the triage unit. Staff told us that there was not a failsafe process for documenting care and advice on electronic systems, and that this impacted on their ability to order investigations such as blood tests in a timely and clearly documented way. Notes were transferred from paper to electronic records by administration staff when they were available, which was not always the

same day. The delay in updating the care record meant that staff may not have accurate and contemporaneous information about women and birthing people's obstetric history. We highlighted this to the trust on the inspection and they provided action plans to mitigate this risk by uplifting the administrative and midwifery staff allocated to the triage unit to ensure records could be updated contemporaneously.

Women and birthing people's medical notes were comprehensive, and all staff could access them when needed. The trust used a combination of paper and electronic records. The trust had plans to complete transition to fully electronic records by September 2023.

The service used several electronic records systems throughout pregnancy. We reviewed 17 sets of records on inspection and found that records were sometimes inconsistent or incomplete, for example, there was not always clear documentation of care pathway in the antenatal period and documentation was not consistent between paper and electronic records. Risk assessment and fetal movements were not consistently documented at each antenatal appointment in 12 out 17 cases. However, staff we spoke to knew where to find the information that they needed, and appropriate information was documented 74% of the time in the notes we looked at.

The service conducted regular audits of record keeping and found record keeping was 88% compliant overall, with 3 out of 15 categories identified for improvement, including use of SBAR.

Staff we spoke to told us that keeping records can increase workload considerably as duplication was required over 2 or more systems. Midwives reported this was particularly difficult when working on the elective caesarean pathway. Staff described a long process of accessing various systems to find the information they needed however, staff were aware of how and where to find it. The service had training booklets and user-guides for bank and agency staff that were unfamiliar with the various electronic systems.

Managers told us that records were audited however we did not see results of this for Chelsea and Westminster Hospital.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, it was not clear if medicines were always stored safely.

Staff followed systems and processes to prescribe and administer medicines safely. During the inspection we found ambient temperatures in areas where medicines were stored were consistently higher than recommendations. The service had recognised this as a risk and there was a complex risk assessment in place. The service provided guidance for staff on actions to take during prolonged periods of high temperatures which can alter the efficacy and shelf life of medicines. However, it was not clear whether the service had accounted for medicines that should be stored continuously at lower temperatures.

We found 2 medicines on the birth centre which were out of date. We escalated this to staff on inspection and they were disposed of immediately.

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 service was implementing a medicines management working group to mitigate this risk.

Staff reviewed each woman or birthing person's medicines regularly and provided advice to women, birthing people and carers about their medicines. Staff completed medicines records accurately and kept them up to date. Medicines records we reviewed were completed in full, clear and up to date.

Staff had access to medicines used to respond to emergencies safely. On labour ward, staff had access to emergency 'grab boxes' to respond to conditions such as pre-eclampsia, sepsis and haemorrhage.

Incidents

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

Managers shared learning from incidents weekly in the form of posters, emails and on social media to reach as many staff as possible. There were safety messages every day at midwife handovers.

Managers monitored incidents for themes. Between July and December 2022, there were 6 postnatal maternal readmissions, and the main theme was infection. This was discussed at risk meetings. The service had put measures in place to reduce the incidence and improve management of uro-sepsis in response to a recorded serious incident, including changing the way results are checked and recorded.

Managers shared learning about never events with their staff and across the trust. 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.

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. However, data showed that some incidents had not been categorised appropriately according to the level of harm) (NHS NRLS guidance, and CQC Regulation 20).

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Managers attended a weekly maternity quality audit and safety (MQAS) meeting at the Chelsea and Westminster Hospital site and once a month this weekly meeting was a cross-site meeting with West Middlesex Hospital.

There was evidence that changes had been made as a result of feedback. For example, there had been a project to improve the discharge process including clearer communication with families about their care.

Managers investigated incidents thoroughly. Women, birthing people and their families were involved in these investigations. We reviewed the last 3 serious incident investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified.

Maternity

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.

Managers monitored open incidents however, incidents were not always resolved in a timely way. At the time of inspection data showed 78 open incidents that were more than 60 days old at Chelsea and Westminster Hospital. Of these incidents, 61 were categorised as low risk.

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, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Maternity services at Chelsea and Westminster Hospital were part of the Women's and Neonatal Services division. This was managed across the trust by a Divisional Director of Midwifery & Nursing. At Chelsea and Westminster Hospital services were managed by a Deputy Director of midwifery supported by four matrons and several specialist and consultant midwives.

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

Matrons often worked clinically on the labour ward to ensure staff could take breaks and they worked clinical shifts regularly as part of their normal job role. Matrons told us that they enjoyed this part of their job as it gave them a real understanding of issues faced and meant they could engage with more staff than they would be able to do if they were solely office-based.

The Director of Midwifery met with the board maternity safety champion every six weeks. 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. The meetings were attended by representatives from the multidisciplinary team including the Deputy Director of Midwifery, service Clinical Director, neonatal lead, anaesthetic lead and the maternity voices chair.

Service leaders conducted comprehensive workforce analyses, training needs analyses and continuously monitored issues facing the service and fed this to board level. There were action plans for improvements following staff surveys, the CQC maternity survey and others. There were obvious, clear lines of two-way communication by service leaders and board level leaders.

Vision and Strategy

Maternity

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 and 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 that 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 and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

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. In Chelsea and Westminster Hospital, 40% of women are Black or Asian, and a further 21% of women consider themselves from other minority ethnic backgrounds.

Staff 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.

Leaders had a strong focus on staff wellbeing and managers ensured staff got their breaks. The service had a staff recognition scheme, staff excellence nominations, multiple emotional and physical wellbeing incentives, a well-established professional midwifery advocate team, career clinics, and education and development opportunities to ensure staff were happy at work. The service supported staff in organising social and team-building events.

Results from the 2021 staff survey showed that staff felt that safe care and treatment was the service's top priority, the organisation listened and acted on concerns, and they would recommend the service to family and friends. However, staff expressed lower levels of morale due to staff shortages and acuity, which was an ongoing issue being monitored and managed by leaders.

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

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

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified theme. In the 6 months before the inspection, there were 22 formal complaints reported to the hospital, and these were investigated and responded to in line with the trust policy.

The service was part of a teaching hospital that supported student midwives in their training. The service ran a student champion group. The group met quarterly to discuss student concerns, challenges and suggestions for improvement. For example, supporting more core staff to become mentors, and developing and facilitating one to one sessions for those wishing to improve confidence and competency in mentoring students.

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. Not all clinical guidelines were up-to-date.

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 women's services meeting every month for Chelsea and Westminster Hospital.

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 women's services 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. Medical staff were also involved in several departmental governance meetings and teaching sessions.

We reviewed two examples of the labour ward coordinators meeting minutes. Labour ward coordinators met to discuss management of unit and any current challenges. Minutes were updated with post-meeting outcomes and solutions.

The audit midwife for Perinatal Mortality Review Tool (PMRT) and the lead consultant obstetrician for PMRT had a weekly meeting to review baby deaths and recent recommendations. There was an ongoing action log to drive improvement. Progress on actions was tracked at the weekly meetings and the trust recommended a completion time of 2 months. 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.

Chelsea and Westminster Hospital worked within the North West London local maternity and neonatal system to drive service improvement according to national incentives such as Ockenden recommendations and the Maternal and Neonatal Safety Improvement Programme.

Maternity

Staff followed 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, the triage operating procedure and induction of labour guidelines. These were in line with national guidance. The service produced a monthly status report for review of guidelines. At the time of inspection there was 1 local guideline and 3 external guidelines that had expired out of 145 total guidelines. A further 22 guidelines were nearing expiry and there was an action plan for management of this.

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 Chelsea and Westminster Hospital the top recorded risks included unanswered telephone calls and challenges fulfilling bank and agency shifts. These were mitigated in a multi-dimensional way including working groups, redeployment of staff, insight reports into the telephony system and purchase of new equipment. The service had clear action plans in place and timeframes for audits and review.

Top risks across maternity services at both the Chelsea and Westminster and West Middlesex sites 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 audits and early escalation of delayed induction of labour, and ongoing recruitment to improve the sustainability of the birth centres.

We saw that the risk register was comprehensive, regularly updated and offered clear information to enable adequate oversight by leaders.

There was a comprehensive and clear risk escalation policy to ensure the safety of the service at all times.

Managers carried out a comprehensive programme of repeated audits to check improvement over time. The service had an annual 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. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. The service collected comprehensive outcome data in a maternity dashboard, which included data on ethnicity to monitor and reduce health inequalities. The service collected data on 3rd and 4th degree perineal tears, also known as an obstetric anal sphincter injury (OASI) and held an OASI clinic to follow up on women and birthing people who have experienced this type of trauma. Leaders regularly reviewed performance in audits at divisional meetings as a standing item on the agenda.

The service monitored levels of screening for women, birthing people, and babies in detail. The service had a shortfall within the screening team that worked across both sites and was monitoring the effectiveness of this. Screening audit data was provided from the previous 4 years and showed consistent compliance with antenatal blood tests and fetal anomaly screening.

Managers shared and made sure staff understood information from the audits. Managers and staff used the results to improve women and birthing people's outcomes, for example analysing reasons for delays in triage and taking steps to mitigate such as implementing the weekday ultrasound clinic.

The service was accredited by the UNICEF Baby-friendly initiative which aims to support families in breastfeeding.

Maternity

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.

Leaders worked across the local maternity and neonatal system to improve services. For example, the smoke-free pregnancy initiative, and system-wide shared learning from serious incidents. We also saw evidence that the trust shared good practice with other trusts, for example the service was commended on consistently high levels of pregnancy immunisation for pertussis (whooping cough) and 'flu and had shared its strategy. This contributed to improved levels of uptake across the region.

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

Medical staff we spoke to told us the most important safety issues were around staffing, escalation, and communication around delays in induction of labour. We asked service leaders about these issues, and they told us that several business cases were in progress for further medical, midwifery and support staff, improvement of the triage unit, and extra consultant cover to assist with delays and patient flow. The service had also looked at ways to improve information sharing and learning regarding escalation and they were seeing good results and positive feedback from staff. These measures have been commented on elsewhere in the report.

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

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. The service and MVP had also co-produced induction of labour information booklet and decision aid tool.

Maternity

The CQC Maternity Survey results for 2022 showed that Chelsea and Westminster maternity services scored in the top five trusts across London in 5 out of 8 areas of care. The service had implemented an action plan in response to areas of improvement identified in the survey including postnatal care, feeding support and user experience as a metric for safe and quality care. 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. There were no questions where the service performed worse than expected.

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. However, the trust's score for workload was significantly below (worse than) the national average. The service was monitoring ways to improve doctor experience, and this has been commented on elsewhere in the report.

The board safety champion ran open forums both virtually and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries. We reviewed activity logs from the maternity safety champions and saw evidence that they were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care within the maternity setting.

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 birthing people and families who had faced maternity trauma and loss. The multidisciplinary team of specialist midwives and psychological practitioners supported women and birthing people with a severe fear of childbirth, 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.

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) 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 and birthing people. 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.

The service had an extensive quality improvement programme focussed on 4 themed workstreams. Focussed areas for improvement included the postnatal discharge process, induction of labour processes, and continued response to service user feedback which was regularly presented at the trust board and had a primary focus on reducing health inequalities for ethnic minority women and birthing people.

Maternity

The service was working towards accreditation from the Capital Midwife Anti-Racism Framework, which aims to improve equality and eradicate racism in the workplace and had completed the actions required to achieve bronze status. The service was shortlisted in the Royal College of Midwives (RCM) 2021 awards for excellence in a global pandemic.

Outstanding practice

We found the following outstanding practice:

- Provision of obstetric-led urgent ultrasound clinics within the maternity triage setting enabled women and birthing people timely access to scans recommended as part of Saving Babies Lives care bundle v2. The clinic provided a 'one stop shop' with continuity of carer where results of scans were discussed, and care planning was completed straight away.
- 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 working towards accreditation from Capital Midwife Anti-Racism Framework to eradicate racism in the workplace.
- 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.
- 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.
- 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 MUST take to improve:

- The service must ensure that all daily safety checks are completed, and all equipment is in date, clean and ready for use. (Reg 12)
- The service must ensure that compliance with appropriate PPE in the maternity inpatients department improves. (Reg 12)

Maternity

- The service must ensure that all staff have the level of safeguarding training appropriate to their role, including doctors, and compliance with mandatory training targets improves. (Reg 12)

Action the trust SHOULD take to improve:

Chelsea and Westminster Hospital, Maternity core service

- The service should ensure all records within the maternity pathway are completed contemporaneously in line with professional standards, in particular: telephone consultations in the triage area. The service should ensure that antenatal documentation is completed including, but not limited to risk assessment and fetal wellbeing. (Reg 17.2)
- The service should ensure compliance with MEOWS chart completion improves. (Reg 17.2)
- The service should ensure recording and monitoring of maternity staffing 'red flag' events takes place. (Reg 12)
- The service should ensure that incidents are harm-rated appropriately. (Reg 17.2; 20)
- The service should maintain safe storage of medicine in all areas including, but not limited to ensuring medicine is in date, medicine is stored at the recommended temperature and risk assessments are reviewed regularly.
- The service should take measures to provide all staff with an annual appraisal.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 CQC team inspectors, 2 midwifery specialist advisors and an obstetrician specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose