Imperial College Healthcare NHS Trust

Queen Charlottes and Chelsea Hospital

Inspection report

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Date of inspection visit: 08 and 09 March 2023
Date of publication: 20/07/2023

Ratings

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

Our findings

Overall summary of services at Queen Charlottes and Chelsea Hospital

Outstanding ☆ ➔➔

The first 2 pages of this report pertain to the hospital location, from page 3 the report focuses on the maternity service.

We inspected the maternity service at Queen Charlotte's and Chelsea Hospital (QCCH) 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 question.

As a result of this inspection Queen Charlotte's and Chelsea Hospital location overall rating has remained Outstanding.

Our rating of maternity remained Outstanding overall.

Maternity services at Queen Charlotte's and Chelsea Hospital include on site and community antenatal clinics, maternity department assessment unit, delivery suites with birthing pool, transitional care, tertiary obstetric medicine (de Swiet Obstetric medicine unit), and a private maternity ward. The hospital is the maternal Medicine Centre for North West London.

The birth centre has seven birthing rooms, three of which have birth pools and ensuite facilities. From 1 April 2022 to 28 February 2023 there were 4,832 deliveries at Queen Charlotte's and Chelsea Hospital.

The trust has two neonatal units which support the maternity services at both sites. QCCH has a level 3 neonatal intensive care unit (NICU) providing special care (SC), high dependency (HD) care, and intensive care (IC) for a range of circumstances. The QCCH NICU has 16 IC / HD cots and 8 SC cots.

How we carried out the inspection

We carried out an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation. Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and families about the trust.

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 ☆ ➔➔

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

- 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 risks and managed medicines well. The service managed safety incidents well and learned lessons from them.
- The leaders had recognised and acted upon the challenges of providing sufficient midwifery staffing and in 2022 had commenced a taskforce to improve recruitment and retention.
- 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 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.
- Staff were committed to improving services.

However:

- At the time of the inspection, we found some gaps in the daily checking of resuscitaires in the birthing centre. The trust took immediate action to address identified gaps.
- At the time of the inspection, whilst we did not find any patient safety concerns, in triage and the maternity assessment day unit we found there was an inconsistent approach to the recording of patient's risk assessments, the prioritisation of their care, triage guidance and the monitoring of telephone waiting times. This was immediately responded to by the trust who reviewed guidelines and processes.

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.

Mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Two practice development midwives and two preceptorship lead midwives supported midwives across both sites.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received an email alert when training required updating.

Nursing and midwifery staff received and kept up to date with their mandatory training. More than 95% of staff had completed all 12 mandatory training courses against the trust's target of 90%.

Medical staff received and kept up to date with their mandatory training. Nearly 98% of doctors in training and nearly 100% of consultants were compliant with completion of mandatory training.

Data provided by the trust demonstrated all clinical staff received obstetric emergencies skills training (practical obstetric multi-professional training - PROMPT) and completion rates were above 90% for both midwives and medical staff. Completion of PROMPT was monitored by the trust's practice development midwives, who notified local leads about the staff's compliance with training.

As of February 2023, over 85% of midwives and 94% of consultants had completed fetal monitoring training. The trust stated 18 midwifery staff were on long term sickness or maternity leave, which had impacted the training compliance figures.

Ninety six percent of staff had completed infection prevention and control training level two core skills as of February 2023.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 92.5% of staff had completed both Level 3 safeguarding adults and safeguarding children training. This was at the level for their role as set out in the trust's policy and in the intercollegiate guidelines and met the trust's target of 90%.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could access the safeguarding team which was made up of safeguarding specialist midwives who oversaw the care of vulnerable women.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed the baby abduction flow chart and undertook baby abduction drills. The maternity voices partnership (MVP) had completed a baby abduction drill on the 18 January 2023 on the postnatal ward and made recommendations. These included repairs to the main doors to postnatal ward as it did not lock, a designated staff member should be responsible for calling security or police, to inform the associate health professionals such as cleaners about the abduction policy and to carry out regular skills and drills training. An action plan was put in place with named members of staff responsible for the outcomes.

Maternity

The trust had a female genital mutilation (FGM) clinic, which offered counselling for trauma for approximately 8 women each week, the counselling covered defibulation, emotional support on childbirth and social support. In addition, the clinic had a Somali Muslim advocate who signposted women to community groups for their future wellbeing and provided information about domestic violence and safeguarding. This provided women and birthing people from this community with a valuable resource where they could feel safe to discuss concerns.

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness. The labour, antenatal and postnatal wards hand hygiene audits, from December 2022 to February 2023, demonstrated an average of 93% compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The trust submitted a sample of audits for the units from December 2022 to March 2023, these were carried out by the Trust's domestic cleaning and maternity midwifery teams. The level of compliance ranged from 93% to 100%.

Staff followed infection control principles including the use of personal protective equipment (PPE).

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.

Leaders monitored the rates of hospital-based infections.

The birthing centre had three birthing pools and staff had undertaken pool evacuation training.

Environment and equipment

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

The service has a high dependency unit (HDU), bereavement room and birthing pool.

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 four high dependency beds for women and birthing people requiring a higher level of monitoring after delivery. The service had a risk of non-compliance with fire safety regulations due to the doors leading into the obstetric theatres not closing because of a misalignment of the upper door bracket hinges. This was rated as an extreme risk on the maternity risk register and had been raised with maintenance with a date of 31 March 2023 to reduce the risk by.

Maternity

During the pandemic, the maternity day assessment unit, (MDAU) was temporarily moved from its original location on the ground floor of the hospital to its current location on the larger David Harvey Unit (December 2021). The reason for moving was the increased activity in MDAU and the inadequate size of original location. In 2022, the maternity directorate submitted a business case to remain on the larger David Harvey Unit on a permanent basis, refurbish the space and move the triage unit into this space, which was formally agreed in January 2023.

The impact of the physical environment to triage and MDAU had affected the directorate's ability to implement Birmingham System-specific Obstetric Triage System (BSOTS) and this was identified as a high risk on the trust risk register.

Staff carried out daily safety checks of specialist equipment. However, we found some gaps in the daily checking of resuscitaires in the birthing centre. Staff explained this was because some rooms had been used for postnatal women overnight. In response to our findings the trust has stated they will undertake weekly audits for a minimum of two months to ensure the practice changes, and then move to monthly audits of checklists if appropriate.

We observed staff disposed of clinical waste safely.

The service mostly had enough suitable equipment to help them to safely care for women and babies. The service had enough suitable equipment to help them to safely care for women and babies. The trust had identified some maternity ultrasound equipment that was over 5 years old and therefore was a priority for replacement in order to meet RCOG national recommendations and was on the directorate risk register.

Partners could choose to stop overnight at the hospital.

Assessing and responding to patient risk

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

The trust had a maternity telephone helpline, for all enquiries, both urgent and general, to the maternity service. This was based at Queen Charlotte's and Chelsea Hospital, which operated between 8.45am and 6.15pm, Monday to Friday and between the hours of 8.45am and 4.45pm Saturday and Sunday. Two band 7 midwives were allocated to support the maternity helpline service. Women and birthing people who contacted the telephone helpline number were provided with additional choices if their waters had broken or they were in labour and they would be re-routed to the appropriate triage telephone. Women and birthing people were also provided with direct contact numbers for labour ward, triage and the birth centre as part of the paper records they kept with them.

Out of hours calls were automatically redirected to triage and were answered on average within 8 seconds. In the three months before this inspection the maternity helpline had received a total of 10,981, of which 1,666 calls were abandoned (15.2%) and the average response time was 7.14 minutes. The trust was looking at whether additional staff were required for the helpline during the day to reduce abandoned calls and waiting times for answering calls.

One band 6 or 7 midwife and a maternity support worker were allocated to triage during weekdays and nights, during the weekend a second midwife was allocated from 12pm to 8pm. Staff explained if they required further support, they would contact the bleep holder.

Maternity

The trust also provided us with 2 audits of phone calls received by maternity triage, carried out in October 2022 and January 2023. These audits identified staff in the triage units answered over 500 calls each month. There were no issues with phone calls in maternity triage, as staff responded out of hours within 8 seconds.

The trust had carried out regular audits of wait times in triage, including time from the woman's arrival to be assessed by a midwife, and a doctor, and the effectiveness of the pathway. The last audit carried out in January 2023 showed that 83% of women had been triaged within 30 minutes, the median time to be reviewed by a doctor had reduced from 2 hours to 1 hour 19 minutes, and the median time for admission to an in-patient bed when required fell from under 5 hours to 2.5 hours.

Whilst the trust was working towards the implementation of BSOTS they had made interim changes. For example, prioritising of triage staff, emphasis on communication between labour ward and triage when activity was high, a review prioritisation, development of standard operating procedure to support less experienced triage staff and ongoing communication with triage staff.

Staff explained they had submitted a business plan to move triage to MDAU, where they were planning to introduce BSOTS. The business plan included an extension to the premises and an increase in the number of staff. At the time of our inspection the premises had been approved and the directors were waiting for the agreement in April 2023 to increase the number of staff, enabling an implementation from October to December 2023.

At the time of the inspection, patients requiring triage were mostly seen on the MDAU, when this was closed patients were seen in the triage unit which was adjacent to the antenatal ward and near the labour ward.

On the triage and MDAU, whilst we did not find any patient safety concerns, we found there was an inconsistent approach to the recording of patient's risk assessments and prioritisation of their care. Staff recorded patient details on the maternity rapid assessment form and the computer patient record system. We reviewed a sample of maternity rapid assessment forms and found staff had not always recorded time of arrival, time seen, level of priority or recommendations. A review of the patient electronic records also found staff completed the risk assessment in the free text. This had also been identified in an audit of triage waiting times, carried out in January 2023, which whilst it did not raise any patient safety concerns, it recommended that documentation to capture arrival and assessment time needed further improvement and evidence of triage prioritisation was still not consistently completed by the midwife.

Our findings were raised with the trust who immediately amended the maternity triage risk assessment tool, priority guide and escalation pathways and included them in the appendix of the amended triage guidelines. In addition, they explained with the implementation of BSOTS staff would use an electronic whiteboard which displayed arrival, triage, and treatment times, along with priorities. The trust confirmed that following the agreement of the proposed business case in April 2023, they would commence staff recruitment which would allow them to have BSOTS embedded by January 2024. In addition, the directorate had submitted another business case to support BSOTS implementation, to reconfigure the midwifery establishment.

Staff shared key information to keep women safe when handing over their care to others. Staff used the SBAR tool (situation, background, assessment, and recommendation) when carrying out a patient handover. An audit in September 2022 where 675 case notes were reviewed found whilst an SBAR handover was undertaken and documented in 100% of cases (free text review of notes), the patient computer record system template SBAR was not consistently completed, that ensured a standardised approach to the recording of the key elements of SBAR. A reaudit was planned for March 2023.

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS) results, which were automatically uploaded onto the computer patient record system which also calculated the score. A MEOWS audit was carried out from September 2022 to January 2023, the areas for improvement were to continue ongoing training and to document the frequency of observations in the care plans.

Staff followed Saving Babies Lives version 2 care bundle. The scorecard demonstrated from October to December 2022 the trust had achieved an acceptable level for most areas. However, the percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth decreased to 33% in January 2023, this was because 1 baby had 2 full doses of steroids prior to transfer and 1 baby was born before 2nd dose of steroids could be administer.

Staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. Monthly audits initially demonstrated a lack of completion of fresh eyes, but this had improved from 71% in September 2022 to 86% in January 2023, the trust target was 90%. The trust had an improvement plan in place and had also raised this as high risk on their risk register for an inability to meet locally set targets for hourly Fresh Eyes CTG assessment standards.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep women and babies safe. On labour ward the consultant held a multidisciplinary meeting twice a day. There was also a safety huddle across the trust daily.

Staff in the birth centre risk assessed women 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 and staff told us they had carried out a pool evacuation exercise.

Occasionally, when there was high level of acuity, and a lack of beds women were transferred between QCCH, and St Mary's. The trust had a transfer standard operating procedure which they had updated and hoped to ratify in April 2023. In response to a request for data the trust audited the number of in utero transfer of women requiring induction of Labour (IOL) from February 2022 to February 2023 which found a total of 39 women had transferred to or from St Marys hospital, and the reasons for transfer were for an elective caesarean, induction of labour and capacity challenges. The trust stated that they did not experience any safety incidents directly relating to the transfer of their care.

The directorate recognised that induction of labour was a high risk on their risk register due to levels of acuity and insufficient staff and had included this in the directorate's improvement priorities. In response, they planned to redesign the induction of labour booklet to provide information on process and what to expect, review of pain relief for women on antenatal wards. In addition, a business plan was submitted for the induction of labour suite to have a dedicated midwife with advanced training, and a designated bedspace. We observed delays in induction of labour were raised as incidents by staff.

We observed staff completed the World Health Organisation Checklists (WHO) in theatres appropriately. The trust provided details of an audit reviewing the five steps to safer surgery, compliance with WHO surgical safety checklist for elective and emergency cases from December 2022 to February 2023. The audit identified that the sign out step at the end of each operation needed the most improvement, and actions had been identified to improve this. Such as the lead operator to ensure that all staff present for time out and to continue with monthly audits.

Staff completed APGAR scores at 1, 5 and sometimes 10 minutes after birth. APGAR is a quick test performed on a baby to determine how well they are doing after being born. Staff also completed NEWS (Neonatal Early Warning Score), which is a traffic-light coded observation chart to enable early detection of adverse changes.

The service provided transitional care for babies who required additional care, which avoids separate of mothers and babies.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge. Staff completed Newborn and Infant Physical Examination (NIPE) assessments of newborn babies before they could be discharged.

Midwifery Staffing

The service had recognised they did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment and had taken action. 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 most recent assessment (July 2022) of the recommended safe staffing ratios for the maternity service compared favourably to Birthrate Plus working fulltime equivalent (WTE). The overall ratio was 23.3 births to 1 WTE midwife, which the trust state they have been compliant with from 1 July to 31 December 2022.

Leaders completed a maternity safe staffing workforce review in line with national guidance. The trust submitted the minutes of the bi-annual midwifery safe staffing workforce trust review for July to December 2022. This stated the current midwifery vacancy rate for band 6 and 7 midwives was 11.2% (37 WTE) had improved from the previous quarter (15%, 47 WTE) due to the introduction of the recruitment taskforce in early 2022. It also noted that the staff turnover had increased to 20% in November/December 2022.

Sickness rates across the directorate from July 2022 to December 2022 had reduced from 7.73% to 4.37%.

Although the trust had planned for their cover, their actual midwifery staffing has been below target in some inpatient areas, particularly QCCH labour ward and the community services. This was responded to through redeployment and temporary daily consolidation of maternity day assessment Unit (MDAU) and triage and use of specialist and senior midwifery staff to support shortfall, and the use of bank and agency staff. In addition, they reported activity was diverted from on site to another approximately twice a week, due to either increased activity or a shortage of staff. Also, in the past six months there had been one occasion when the trust had been required to restrict access and request support from the sector. This was for a period of less than 4 hours.

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 59 red flag incidents reported between 1 July and 31 December 2022. These comprised of 34 regarding staff shortages, 23 increased abnormal workload and 2 regarding lack of beds. Since January 2023 the trust had 10 red flags, four regarding delayed induction of labour. We also noted from the incidents reported that triage was closed on four occasions when there was insufficient staff.

The trust had recognised the inadequate provision of workforce as an extreme risk on their organisational risk register, which had the potential to affect their ability to provide safe patient care , a sustainable elective caesarean section list and a risk of delay in providing timely induction of labour to women.

From 1 July to 31 December 2022 the compliance rate reported for one-to-one care was 98-100%. In addition, the rosters for the labour wards were planned to always allow for one supernumerary coordinator.

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 babies accessing the service.

In response to the workforce challenges the trust had set up a midwifery recruitment taskforce and a retention subgroup in 2022, who were looking at flexible working patterns and self-rostering by staff to improve retention. Their Initial aim was to recruit at least 10 band 6 experienced midwives over the year but had exceeded this with 13 recruited. A recruitment and retention midwife had been appointed; a maternity bleep holder team was established of five full time staff who had oversight of both sites. The units had twice daily maternity staffing huddles, staff worked across site, a senior midwife on call rota, and redeployment of specialist midwives and the senior team into clinical shifts. A business case was in progress to request additional lists for the increased caesarean section trends.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 84 % of maternity staff had received a yearly appraisal as of March 2023. Managers made sure staff received any specialist training for their role. The trust policy was for new starters to not have an appraisal in their first 6 months in post, which affected the overall compliance rate.

Medical staffing

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

Staff said the service had enough medical staff to keep women and babies safe on labour ward. The consultant on site cover was from Monday to Friday 8am to 11pm, and at weekends 8.30am to 8pm. (98 hours cover per week) There was a consultant rota for offsite cover for labour ward and the consultants had remote access to patient records and all lived within half hour travel of the hospitals. The rota ensured that consultants were present and available for direct or indirect supervision for the majority of cases. Where cases occurred out-of-hours and the consultant was no longer on site, the senior trainee would contact the consultant. Where the trainee required support, the consultant would attend.

This was audited against The Compliance with Royal College of Obstetrics and Gynaecology workforce document ‘Roles and Responsibilities of a Consultant Obstetrician & Gynaecologist’ from August to December 2022. Which demonstrated substantial assurance that a consultant was present for all clinical situations when a consultant was required to attend

in person. Except for those which took place out of hours, where the senior trainee was deemed competent and felt confident to undertake the procedure/delivery. In addition, the consultant had agreed to the senior doctor undertaking the procedure. The consultant input into care of women on maternity high dependency unit, was found to be appropriate and regularly reviewed.

The audit included a survey of senior house officers and registrar doctors to determine whether senior trainees had felt adequately supported by consultants whilst on-call. The registrars confirmed very good support from the consultants, and they always attended out of ours if requested. The senior house officers had a mixed response most stating they were very or somewhat satisfied with senior support.

Multidisciplinary handover and twice daily consultant led ward rounds was carried out on labour ward. A consultant was allocated to the delivery suite.

The trust submitted information that Queen Charlotte's and Chelsea Hospital had 13 obstetrics and five obstetrics and gynaecology consultants and a total of 42 doctors' junior doctors from April 2021 to March 2022. This was for a birth rate of approximately 4901 over 11 months.

The maternity scorecard for December 2022 stated to date that the trust had achieved 100% compliance for obstetric unit providing a dedicated consultant presence 12 hours per day, 7day/week.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust submitted evidence the medical staff appraisal compliance rates were over 90%.

Records

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

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

We reviewed 16 women's records on inspection and found records were mostly clear and completed. Except for CO2 monitoring at 36 weeks, which was not completed for 7 records and swab counts that were not completed in four records. The staff explained that the staff they had documented the monitoring and swab counts in the free text of the patient's electronic records (EPR), because of an issue with the EPR not allowing the correct fields to be populated, which has now been repaired.

We found the trust were monitoring the CO for 36 weeks as part of the Clinical Negligence Scheme for Trusts (CNST) and had achieved over80% compliance by January 2023.

At the triage and MDAU unit we found there was an inconsistent approach to the recording of patient's risk assessments and prioritisation of their care. This was also identified in an audit of triage waiting times, carried out in January 2023, which, whilst it did not raise any patient safety concerns, it recommended that documentation to capture arrival and assessment time needed further improvement and evidence of triage prioritisation was still not consistently completed by the midwife.

Maternity

In response to the Ockenden report in 2022, the action plan included, that the directorate would develop a mechanism within the computer patient records system to easily alert staff to note and respond to risk assessments at each contact, which they hoped to complete in March 2023.

The maternity services scorecard for December showed that 100% of women had a personalised care plan in place.

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.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. All the medicines record we reviewed were clear and up to date.

Staff stored and managed all medicines and prescribing documents safely. There was a moderate risk identified and, on the risk, register in regard to the safe storage of medicines with in maternity obstetric theatres, which they hoped to meet the target of by 31 August 2023.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services and discharged.

There was a system in place to ensure staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave 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 directorate had one never event which occurred in the theatres at St Mary's Hospital, which was caused by failure of the operating team to complete the WHO checklist prior to Caesarean section. Learning from the event was shared across sites and lead to reminding staff at the post graduate forums and multidisciplinary meetings of the importance of completing the WHO checklist.

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 and families a full explanation if and when things went wrong. For example, the

trust had reported 15 incidents to the Healthcare Safety Investigation Branch (HSIB) for investigations and 9 cased has been accepted, 7 were completed of the seven completed five occurred at QCCH. We saw action plans were implemented in response to the HSIB findings, the progress of the action plans was monitored through the maternity and quality and safety committee, and information was communicated to staff through the maternity safety newsletter.

For the month of January 2023, the staff had reported 119 incidents at QCCH.

Incidents reporting performance was monitored by the local maternity safety meeting and maternity quality oversight assurance group, and serious incidents were reviewed by the clinical team meeting monthly. In February 2023 there were 64 open actions with 17 outstanding actions from incidents.

Staff met to discuss the feedback and look at improvements to the care of women.

Staff received feedback from investigation of incidents, both internal and external to the service. Feedback was shared by managers, through a newsletter, learning slides which were displayed in staff rooms, and during the safety teams huddles.

There was evidence that changes had been made as a result of feedback. A theme of failure to identify abnormal urine results had been identified. In response managers implemented an improvement group and plan, the plan included allowing more staff to see the results, improving the process, sending automatic letters or text tests if the urine results are normal and shared learning from incidents to help staff understand why it's important and why the process needs to change.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations.

Staff told us that managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good ➔➔

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

Leadership

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

There had been a change in the in leadership following our previous inspection in February 2019. For example, two of the three lead roles for the division of Women's and Clinical Support the divisional director and divisional director of nursing, entire maternity directorate triumvirate, the lead midwife for governance and risk and both labour ward matrons had changed. In addition, the maternity service structure had changed and there were new roles implemented for the head of midwifery at each site. Despite the changes, the maternity service continued to operate at normal levels and staff at QQCH commented positively about the service and the leadership.

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Maternity services at Queen Charlotte's and Chelsea Hospital were managed as part of the women's services maternity directorate.

Maternity services across the trust were managed by a triumvirate of a clinical director, a general manager, and an associate director of midwifery They were supported by a range of staff including, head of midwifery, matrons, obstetric heads of specialty and business managers.

All senior leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The divisional director for the clinical division of Women's and Clinical Support explained the difficulties in recruiting to the post of director of midwifery, which had been vacant prior to September 2022 and how there was ongoing recruitment to this post. At present there was an associate director of midwifery in place who was supported by two heads of midwifery, a deputy general manager and two business managers.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. Maternity leads worked clinically on the delivery suite to support staff.

The executive team and safety champions visited wards on a regular basis. Staff told us they saw the executive team and senior managers.

The service was supported by maternity safety champions and non-executive directors. The maternity directorate triumvirate met with the board safety champion every month. The maternity board safety champion and the associate director of midwifery were aware of issues relating to the quality and safety of the service and an advocate for the service at board level.

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

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Women's services had a clear vision and strategy developed in line with the trust's objectives and goals. The 2023 strategy focused on 3 priorities: to create a high-quality integrated care system, to develop a sustainable portfolio of outstanding services, and to build learning, improvement, and innovation.

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Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. Delivery of the trust's Ockenden action plan had been included in their strategy for 2023. Updates were regularly mentioned as part of monitoring and governance processes, such as the Divisional Quality and Safety Committee meetings and the executive management board quality group.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Imperial College Healthcare NHS Trust formed partnerships with other trusts across North Wst London to collaborate on improving healthcare provision. This formed one of the priorities in the trust's strategy with the aim to create a high-quality integrated care system for the population of North West London.

Leaders and staff understood and knew how to apply and monitor progress of the strategy.

Culture

Staff 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.

Staff were positive about the hospital, its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff told us they were supported by other staff. Staff members told us relationships between consultants and midwives were positive.

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

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. The trust had developed a system where specialist advocates, interpreters and staff were all able to feed into supporting women and birthing people throughout their maternity journey. This provided support during and following pregnancy for women and birthing people who had experienced female genital mutilation (FGM), babies who were at risk of FGM and those from parts of the world where this was practised.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

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

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

The maternity directorate under the 'happier working lives' initiative, held a maternity refresh and reset session, in February and March 2023, to help improve work culture through promoting psychological safety, compassionate leadership and inspiring a mindset.

The retention group had set up a flexible working project to increase staff retention in November 2022.

Governance

Leaders mostly 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 mostly operated effective governance processes, throughout the service and with partner organisations.

The trust had policies to plan and deliver high quality care according to evidence-based practice and national guidance. Monthly quality and safety meetings showed guidance that needed to be reviewed was identified and returned to the meeting to be ratified once reviewed.

The service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. These included directorate performance support meetings, executive management board quality group meetings, and maternity oversight meetings.

The trust worked with other acute healthcare providers as part of the North West London acute provider collaborative. This strengthened decision-making and helped the trust make effective use of resources to provide better care. Maternity services were discussed as a standing agenda item and this included responses to the findings of national reviews, such as Ockenden and East Kent.

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

The maternity service contracted out to a private company for a homebirth service. The trust was able to provide details of Disclosure and Barring Service (DBS) checks which were undertaken where required and details of staff competency.

The maternity directorate had a workforce strategy programme workforce supply, employee experience, leadership and people management, education, and workforce design. The strategy included deliveries and measures.

Management of risk, issues, induction, 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.

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The service participated in relevant national clinical audits. Staff at the trust completed audits for several national programmes, such as the National Maternal and Perinatal Audit and the National Perinatal Mortality Review. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. For example, in response to preterm births the directorate followed the bestprem care bundle to ensure the best start to life for survival without significant morbidity and was working towards achieving over 90% compliance with the 12-element perinatal care, which improved babies' chances of survival, reduced brain injury and empowered parents' experience.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

However, at the time of the inspection although we found no evidence of unsafe practice, we found the identified risk of incomplete documentation in triage audits had not been acted upon fully, whilst the service was awaiting the implementation of BSOTS and new patient computer software. This was immediately rectified following the inspection.

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

The trust had a maternity risk register in place which identified any risks to the service and leaders were aware of the five main risks on the trust's register.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. We found where the staff had identified a risk this had been monitored and an improvement plan implemented, such as for fresh eyes, induction of labour, and recruitment and retention of staff.

In response to the identification of issues and incidents which occurred in antenatal care, such as delays in arranging follow up for patients who did not attend their appointments, a task and finish forum for antenatal care was established for six months. The group had clear objectives such as regular monitoring of follow up appointments and had an action plan with set goals, which was reviewed every two weeks.

Information Management

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

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible toall staff . Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

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The information systems were integrated and secure.

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

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 leaders had put an action plan in place in response to the maternity staff survey results in 2022, where some staff felt aspects of the service needed to improve. For example, themes arising from the 2022 survey included work pressure, thinking about leaving and health and wellbeing. Actions undertaken by the trust included staff wellbeing boards displayed, monthly listening sessions. Information on Freedom to speak up and escalation process for raising concerns and monthly unit listening sessions. Maternity directorate engagement meetings were planned for each month.

Staff received a monthly maternity team news update, this included information about recognising staff, information from the recruitment and retention task force, winter wellbeing for staff.

The trust had posters displayed regarding what the staff said and what the trust were doing. Examples of this were to get staff allocated breaks was an ongoing project to ensure break relief. In addition, staff said they wanted to be valued and recognised for your work and in response the trust created Cherry on top of the Cake Values Award- Celebrating excellent work.

The trust had a safety culture programme HOTT (Helping Our Teams Transform) which was born out of the 'Safer Surgery' safety stream running since 2019. HOTT was invited to work with the maternity staff team regarding the Ockenden report, and serious incidents. Several conversation cafes were held with staff in September 2022 and a report was submitted that identified immediate needs, and six key recommendations based on HOTT's expertise in the arena of patient safety and quality improvement. Thirty-nine members of staff that worked from QCCH took part. Examples of key learning and outcomes was staffing was a large factor in the teams' problems and concerns, and lines of responsibility for certain parts of the antenatal pathway are not always clear. In response the trust used the antenatal a task and finish forum and the recruitment and a retention subgroup to make improvements.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. In response to the finding of the Ockenden report, the trust had implemented a maternity voices partnership action plan, which included implementing, quarterly meetings, building relationships with local community groups, and holding listening events.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. Additionally, the trust had recently carried out a trial of an interpreter on wheels service, a tablet mounted to a rolling platform that connects to an online platform in which human interpreters located anywhere in the world can provide confidential interpretation services via video and audio streaming.

At the time of the inspection, the trust were waiting for a North West London sector-wide pilot for a communication tool designed to improve the transfer of vital information between healthcare staff and patients, including where there are language barriers to commence.

Maternity

Leaders understood the needs of the local population. One of the trust's priorities for improvement was patient engagement. As part of the improvement, they had commenced the family big room, which was held in a local community centre and involved staff, volunteers and the maternity champions engaging with the residents. This offered a safe space for residents to discuss and feedback about sensitive issues such as the complex causes of differential outcomes between people of colour.

The friends and family survey results for December 2022 demonstrated over 80% positive response to their patient experience.

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.

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. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

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

The trust listed their present quality improvement work under the headings of induction of labour, implementation of BSOTS, safety workstreams making improvements to abnormal midstream urine results and fresh eyes, maternity/ neonatal projects and service user engagement.

The trust had responded to the HOTT report and looked to make improvements by:

- Submitting a business case for all day caesarean section lists to be extended.
- Submitting a business case to build resilience into the consultant workforce, which would also support the implementation of recommendations from the final Ockenden report.
- Appointing 2 obstetric nurses and advertising for a technician role to assist and support midwifery colleagues.
- Reviewing whether to appoint additional maternity support workers to undertake some of the tasks that fall on midwives in the antenatal and community clinics.
- Making changes to the patient computer record system to make it easier to review document many of the key areas.
- Improving team building thought he Happier working Lives programme and Schwartz rounds.

Outstanding practice

We found the following outstanding practice:

- The trust had a female genital mutilation (FGM) clinic, which offered counselling for trauma for approximately 8 women each week, the counselling covered defibulation, emotional support on childbirth and social support.

Maternity

- The clinic had a Somali Muslim advocate who signposted women to community groups for their future wellbeing and provided information about domestic violence and safeguarding.

Areas for improvement

Action the trust SHOULD take to improve:

Queen Charlotte's and Chelsea Hospital:

- The trust should ensure that the daily checking of the resuscitaires takes place in the birthing centre. (Regulation 12)
- The trust should continue to ensure that there are sufficient staff to provide safe care. (Regulation 18)
- The trust should continue to ensure staff carry out 'fresh eyes' to ensure fetal monitoring is carried out safely. (Regulation12)
- The trust should ensure that staff fully complete the assessment forms in triage. (Regulation 12)
- The trust should monitor the implementation of all reviewed or newly amended policies and procedures in regard to the triage.(Regulation 12)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspectors, a CQC specialist adviser team of two midwives and a consultant obstetrician. The inspection team was overseen by Carolyn Jenkinson Deputy Director of Secondary and Specialist Healthcare