Homerton University Hospital NHS Foundation Trust

Homerton University Hospital

Quality Report

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Date of inspection visit: 17, 23, 24 March 2015
Date of publication: 17/08/2015

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Maternity and gynaecology	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Homerton University Hospital provides maternity services for the local community of around 252,000 people in the London borough of Hackney.

The maternity unit delivered over 5,500 babies in 2014. There is a consultant led delivery suite as well as a midwifery led birth centre. The maternity unit is supported by a level 3 neonatal unit.

We inspected the hospital in February 2014 when we rated the maternity service as good for all fiveareas we look atand good overall. In response to concerns we undertook an unannounced focused inspection of the maternity unit on 17 March 2015 and an announced inspection on the 23 and 24 March 2015. Concerns had been raised by the Clinical Commissioning Group (CCG) and an external review into four of the maternal deaths between July 2013 and April 2014 which was shared with us on 24 February 2015.

Our key findings were as follows:

Safe:

- There were systems and processes in place for reporting and investigating serious incidents and deaths but not all incidents inmaternity service were reported.
- Therewere unacceptable levels of serious incidents and never events.
- Reported incidents wereinvestigated but the response was slowresulting in continued potential risks to mothers and their babies.
- Staff were not proactive in maintaining a safe environment and boththe environment andequipment werenot appropriately cleaned.
- The wards had the required equipment. However resuscitation and emergency equipment had not been consistently checked to ensure it was ready for use.
- Drugs were not administered or stored safely in the maternity service.
- Midwifery staffing levels wereless than the recommendations of Birthrate Plus. Some shifts on the labour suite were staffed predominately withbank and agency staff.
- The trust's safeguarding policy was out of date and did not reflect the latest national guidance.

Effective:

- The unit's performance was outside the trust's internal and national targets for many of theoutcomes monitoredsuch as sepsis, post partum haemorrhageand the number of births by normal delivery.There was limited evidence of action being taken to address these areas.
- There was limited evidence that audits undertaken had positively influenced practice.
- Many of the clinical guidelines had been reviewed and were up to date.
- Women and babies nutritional, hydration and pain relief needs were managed.
- Maternity care assistants were responsible fortaking the observations of mothers and babies, however there was no processto ensure they were competent to undertake this task.
- The majority of midwives did not understand the Mental Capacity Act (MCA) and their responsibilities in this area.

Caring:

- Most women and their partners were positive about the care they received. They understood and felt involved in their care.
- Most women and those close to them received the emotional support they needed.
- There was a low response rate to the Friends and Family Test (FFT) andstaffwere unaware of the feedback from this survey.

Summary of findings

- Limited action had been taken in response to the national maternity survey (2013)and action plans developed to respond to the findings were notmonitored.

Responsive:

- Staff were aware of the demographics of their local population and responsive to the needs of established ethnic minority groups but not to other groups.
- Family members were often used to translate.
- Complaints were not responded to in line with the trust's policy and response times.Staff were unaware of anylearning orchanges in practice in response to engagement with the people using the service.

Well-led:

- The vision and strategy for maternity services was not well established.
- Staff gave positive feedback about the leadership and culture of the service.
- There were identified leadership roles in the maternity services, at ward level, staff felt supported by the matron and ward sisters.
- Some performance data was unreliable and not used consistently to identify poor performance and areas for improvement.
- Key risks were not recorded on the risk register and mitigating action had not been taken.
- Poor standards and performance was not consistently challeneged by the patient safety committee.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure all incident investigations are completedin a timely manner, taking into account wider factorsand embedded into practice, sharing learning trust wide as appropriate.
- Review the standards of cleaningand the maintenance of the environment and equipment taking action to ensure they are fit for purpose.
- Ensure all staff adhere to the trust’s guidance on the use of MEOWS including routinely determine frequency of observations of women.
- Review the outcomes for mothers and take appropriate action to address adverse outcomes.
- Improve the quality and accuracy of performance data and increase its use in identifying poor performance and areas for improvement.
- Ensure the risk register includes all key risks and mitigating actions to reduce these risks.
- Identify common actions or issues in action plans to facilitate a more co-ordinated approach to learning and improvement.
- Ensure interactions on the postnatal ward are not task specific.

The trust should:

- Display information to demonstrate the service’s performance against safety measures or targets in all clinical areas.
- Ensure the signage to maternity services is clear to avoid ambulance crews and mothers and their partners experiencing delays in accessing services.
- Action should be taken to ensure all medicines are stored securely to avoid unauthorised access.
- Improve the standard of record keeping, consistently recording mothers and babies observations, MEWOS and fluid balance.
- Review the security arrangements in the service to prevent unauthorised access to wards and the removal of babies from the delivery suite or postnatal ward.
- Review the training provided to maternity care assistants to ensure they have the necessary skills and competencies to deliver safe care to mothers and babies.

Summary of findings

- Use a neonatal early warning score to record baby's observations including taking their temperatures within one hour of birth.
- Ensure all policies reflect current national guidance and these are communicated to all staff. Including drafting and implementing a maternal collapse policy in line with professional guidance.
- Ensure all staff are familiar with the structured communication tool method Situation, Background, Assessment, Recommendation (SBAR) and are able to use this tool effectively.
- Review staffing and skill mix, including the percentage of non-permanent staff used to ensure they are appropriate to meet the needs of mothers and their babies.
- Ensure all midwives understand the MCA, how this relates to their practice.
- Explore ways to improve the response rate to the FFT and alternative ways to collect feedback from mothers and their partners.
- Improve the provision of translation services and availability of written information in a range of languages other than English.
- Improve the response times to complaints.
- Explore ways to increase the level of enquiring and challenge among staff in relation to poor standards and performance.
- Develop theleadership skills ofshift leaders to prepare them for this role and hold them accountable for their performance.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Requires improvement 	The maternity unit reported a high number of serious incidents including two maternal deaths in 2013, two in 2014 and a further one in January 2015. The service was not consistently learning from all these adverse incidents and implementing all the necessary improvements. Woman and their babies were not always being adequately monitored. The environment and equipment were not appropriately cleaned. Equipment was not consistently maintained or checked. The unit engaged positively with mothers and their families from some established communities but not so with all communities within the local population. Staff sometimes relied on family members to provide translation services and the majority of leaflets available were in English. Mothers and their families reported mixed responses to the care they received. The service did not have a well established vision or a strategy and governance process were not fully embedded in practice. The risk register did not include all significant risks. Staff gave positive feedback about the leadership and culture of the service. We found the majority of issues identified at our first unannounced inspection, such as the environment, documentation and patient safety, which the trust stated they had taken action to address, had not been resolved when we returned one week later for an announced inspection.

Homerton University Hospital

Detailed findings

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Detailed findings

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Background to Homerton University Hospital

Homerton University Hospital became one of the first 10 NHS foundation trusts in England in 2004. The trust is a medium-sized hospital providing acute, specialist and community services to Hackney and the City of London. The trust served a diverse population: the London Borough of Hackney and the City of London. In 2010, the Indices of Deprivation showed that Hackney was the second most deprived local authority in the country, the City of London has an increasing population and was judged as being the 262nd most deprived local authority out of 326.

The trust provided specialist care in obstetrics and neonatology, foetal medicine, fertility, HIV, keyhole surgery, asthma and allergies, bariatric surgery and neuro-rehabilitation across east London and beyond. The hospital employees around 3,500.

Approximately 5,600 babies are born at the trust every year. There were three maternal deaths in the year April 2013 to March 2014 and a further two deaths in the year April 2014 to March 2015. This compares with a national average rate of maternal deaths of 8.6 per 100,000.

The hospital had been inspected eight times since registration. The last inspection was in February 2014 and the maternity service was rated as 'good'.

In direct response to concerns we undertook an unannounced focused inspection of this unit on 17 March 2015 and an announced inspection on the 23 and 24 March 2015. Concerns had been raised by the Clinical Commissioning Group (CCG) and an external review into four of the maternal deaths which occurred between July 2013 and April 2014 was shared with us on 24 February 2015. We inspected maternity services only.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

Inspection manager Fiona Wray, Care Quality Commission

The team included CQC inspectors, CQC's National Professional Advisor - maternity and specialists advisors.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

Before visiting, we reviewed a range of information we held about the organisation.

We carried out an unannounced inspection visit on 17 March 2015. We spoke with a range of staff in the hospital, including midwives, maternity support workers, junior doctors, consultants, administrative and clerical staff. We carried out an announced inspection on 24 March 2015.

During our inspection we spoke with mothers and their partners. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

Facts and data about Homerton University Hospital

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Maternity and gynaecology

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The hospital's maternity unit is a large provider of services having delivered over 5,500 babies in 2014. There is a consultant led delivery suite as well as a midwife led birthing centre. The maternity unit is supported by a level 3 neonatal unit.

Summary of findings

The maternity unit reported a high number of serious incidents including two maternal deaths in 2013, two in 2014 and a further one in January 2015. The maternity service was not consistently learning from all these adverse incidents and implementing all the necessary improvements. Women and their babies were not always being adequately monitored. The environment and equipment were not appropriately cleaned. Equipment was not consistently maintained or checked.

Overall mothers and their families were satisfied with the care they received. The unit engaged positively with mothers and their families from some established communities but not so with all communities within the local population. Staff sometimes relied on family members to provide translation services and the majority of leaflets available were in English.

Staff gave positive feedback about the leadership and culture of the service however the service did not have a well established vision or a strategy and governance process were not fully embedded in practice. The risk register did not include all significant risks.

We found the majority of issues identified at our first unannounced inspection, such as the environment, documentation and patient safety, which the trust stated they had taken action to address, had not been resolved when we returned one week later for an announced inspection.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

Safety was not a sufficient priority. There had been a total of five maternal deaths between July 2013 and January 2015. There had been a never event in January 2015 and 29 serious incidents reported in 2014. There were systems and processes in place for reporting and investigating serious incidents and deaths. However, not all incidents were reported and the scope of the investigations were narrow and did not take into account wider factors. Action taken following serious incidents was often delayed and not fully embedded into practice.

Some staff showed a limited understanding of the serious incidents and learning was not shared outside the service with other departments in the hospital. Training had limited impact on staff practices and midwives did not participate in many of the opportunities to learn from incidents.

Staff were not proactive in maintaining a safe environment. Many areas were not cleaned to appropriate standards and equipment was not consistently maintained. The standard of record keeping and the failure to escalate concerns effectively resulted in risk to mothers and babies. Women's personal information and medications were not consistently stored securely .

Incidents

- During 2014 there had been 29 serious incidents (SIs) in maternity services. There were systems in place for escalating all deaths to the chief nurse & director of governance and other senior managers.
- There had been a never event in maternity in January 2015. A never event is a serious, largely preventable incident that should not occur if appropriate preventive measures had been implemented. The event related to a retained vaginal swab, found by the patient's GP eight days post delivery. The internal investigation showed that no count of swabs had been recorded before the procedure, but the swabs had been counted afterwards.
- Although action plans from never events were a standard item on the patient safety committee (PSC) agenda there was insufficient challenge to ensure the pace of action was appropriate. There was limited evidence of there being accountability or responsibility taken by staff for the completion or monitoring of action plans, at clinical, managerial or executive level.
- Debriefing sessions were held with all staff involved after SI's. The discussions and who attended these debriefing sessions were not recorded. Senior staff said they considered learning from all incidents was shared effectively. Junior doctors also reported that the learning from incident investigations was very effective. However, the majority of midwives and doctors we spoke with were unaware of the never event.
- In the 2014 staff survey the trust scored significantly better than average for staff being informed of errors and the outcome of investigations. Staff were significantly more confident than average that the trust would address unsafe clinical practice.
- We noted in the two weekly newsletters produced by maternity service, known as "Tips of the Fortnight", circulated by email, that staff had been reminded to count swabs in 2011, 2012, February 2014 and March 2015. However, there had been no formal action to ensure all staff were aware of and adhering to the trust process following the never event in January 2015.
- We were told learning was discussed with midwives and doctors at handovers, but this was not the case at the handovers we observed. Learning was also an agenda item on the Friday morning obstetric meetings, weekly perinatal morbidity meetings and the monthly perinatal mortality meeting. However, these meetings did not include the majority of midwives. Several midwives we spoke to said they had not attended Friday meetings for some time, and evidence from sign in sheets confirmed this.
- There were 1,320 maternity incidents reported in year 2014, representing a reporting rate of about 192 per thousand, placing the service in the top 25% of reporting hospitals. In the past two months 43% of clinical incidents related to healthcare records, data quality and patient ID. The main theme of non-clinical incidents had been communication.
- On inspection we noted a serious incident that occurred in February 2014. The staff we spoke with unaware of the incident and that any learning had happened in response.
- We noted the incidents reporting process and practices were often insufficient and too slow. An action for

supervisors of midwives for 2014/15 was to complete incident reviews within the 45 day timeframe as expected by the NMC, however, this timescale was not being met.

Maternal deaths

- There had been five maternal deaths between July 2013 and January 2015. We were told that all maternal deaths were discussed in a variety of meetings including the perinatal grand round to identify learning. However, no midwives we spoke with and only doctors were aware of the deaths or had taken learning from them.
- We were told that maternal death investigations focused on the root cause of death. Senior staff told us wider issues such as the competence of staff involved, skill mix, equipment in use at the time, who was on duty and the day and time of day had not been taken into account as part of the investigation, therefore limiting the scope of investigations and opportunity for learning.
- Some staff we spoke with were not aware of the learning or actions taken following the maternal deaths. Staff who had been directly involved in the incidents told us that the learning from the recent maternal deaths had included extending the use of the modified obstetric early warning system (MEOWS) to assist staff in recognising deteriorating patients and that it was included in mandatory training. Some staff thought that this document was out for consultation while others thought it was in a final draft and awaiting sign off. There was no evidence that the observations of women had improved.
- We were told that all action plans following the investigations into the maternal deaths were monitored monthly by the patient safety committee (PSC) with the maternity team providing verbal or written evidence that the actions had been completed. Senior staff told us they were confident that the action plans following the two maternal deaths in 2013 had been delivered on time and that most actions had been completed. However, evidence provided showed that not all actions had been completed 18 months after the first mother's death. A one day training course for theatre staff with follow up sessions, had not taken place, it was stated that it had been difficult to arrange this training for all staff as it was provided by an external company.

Safety thermometer

- There was no information on display in either the delivery suite or the postnatal ward about how the service was performing against safety measures or targets.
- The unit aimed to carry out risk assessments for venous thrombo-embolism (VTE) within 24 hours of admission. The target was to assess at least 95% of women but this target had not been met for eight consecutive months in 2014. To improve recording changes to the electronic patient record had been made, a question about VTE had been added to the postnatal handover of care form and staff had been sent reminders about the importance of VTE assessments. The completion rate had improved to 96% in February 2015.

Cleanliness, infection control and hygiene

- The standards of cleaning in all areas of the maternity service were poor. They did not meet the Code of Practice on the prevention and control of infection (2008) which requires providers to maintain a clean and appropriate environment.
- Senior staff stated cleaning was done frequently and was compliant with national specifications for cleanliness in the NHS (April 2007) we found this not to be the case. We were told that the cleaning concerns identified on inspection such as the dirty environment, dusty equipment labelled as clean and ready to use had never been raised as an issue. The cleaning of clinical equipment was the responsibility of midwives and there was an expectation that this was checked by the matrons and senior staff daily. However these checks had not been undertaken. We noted on the postnatal ward electronic blood pressure machines had stickers to indicate that had been cleaned that morning but four of the five machines were visibly dusty.
- There were no cleaning schedules on display and clinical staff were complacent about cleanliness. The domestic cleaning schedule provided on inspection included daily high level dusting this had not taken place. We also observed a hanging rope in a birthing room was stained and encrusted with blood and other body fluids, a cot ready for use in the delivery room was dirty underneath the mattress indicating it had not been cleaned to an acceptable standard and the floor was visibly dirty and blood was noted on the radiator in the triage room. We highlighted the issues to staff, however when we returned one week later the issues had not been addressed.

- The curtains around each bed space were labelled with a date when they had been changed and were visibly clean.
- On the antenatal and postnatal wards we saw an infection control checklist that included ensuring alcohol gels were at the entrance of the ward. We were told that the checklist was completed by the maternity care assistant and we noted the checks had been completed for the majority of days up to the week prior to our inspection. However, there was no checklist completed for the week of our inspection. The shift leader, who was responsible for ensuring the maternity care assistant had completed all her tasks, was unable to provide a reason for this. We were later informed these checks had been discontinued. No rationale for this change was provided.
- All staff wore appropriate uniforms but we noted some staff wore jewellery.

Environment and equipment

- The adult resuscitation trolley should have been checked daily in line with hospital policy but records demonstrated it was not checked daily on 20 and 23 March 2015 in the current month. The Massive Obstetric Haemorrhage trolley had not been checked on 13 days during the month of March 2015 despite a recent maternal death.
- The maintenance of some equipment in the maternity services was inadequate. There was no inventory of equipment, recalibration of measuring equipment or preventative maintenance programme. If an item was in use when contractors carried out portable appliance testing (PAT) there was no way of knowing that the item had not been tested. About 50% of electrical items we reviewed were overdue for electrical safety testing. Stickers indicated that some equipment had not been tested since 2013. This included scales, sonic aids and blood pressure machines. Ward staff did not alert estates staff to equipment that was overdue for testing. There was no indication of calibration checks on baby scales.
- The milk fridge on the postnatal ward recorded a temperature of seven degrees, a notice on the fridge stated that this temperature should be four degrees. We were told that the temperature of the fridge was recorded daily; however, the record of these checks could not be located to show that they had been undertaken daily.
- Each bed space in the OAU had electronic monitoring that was linked to blood pressure and cardiotocography (CTG) machines. However, only three of the five monitors were fully functioning and one monitor was not working at all.
- The labour ward was adequately equipped. Birthing rooms were spacious, equipped with piped oxygen and entonox and had en-suite facilities. Staff told us there were enough CTG machines, used to monitor the foetal heart in labour, even at times of heightened activity. Sufficient electronic blood pressure machines, and a foetal blood gas analyser and emergency adult resuscitation trolley were also observed on the labour ward.
- The signage for maternity was confusing with no reference to maternity on entry to the hospital. The signs for antenatal and foetal medicine unit, which had moved to a new location at the beginning of 2015, were temporary paper notices, some torn. The permanent signage for the former entrances to these areas were still in place, leading to confusion for visitors.

Medicines

- Medicines were not always stored securely and unauthorised people could have access to drugs. On 17 March 2015 we observed an open cupboard containing drugs, in an open room on the labour ward, which was often unattended. On 23 March, on the birthing unit, we found an unlocked drug fridge in an unlocked room with the door propped open.
- We noted that lidocaine ampoules had been left on a trolley in an empty delivery room and the door was open. This practice is contrary to the trust's policy which stated that ampoules should be stored in their original containers at all times, and that drugs should be in locked cupboards.
- Storage of high dose opiates had been the topic of a National Patient Safety Agency (NPSA) alert on 25 May 2006. However, the service failed to embed this into practice. The nurse consultant for medicines management at the hospital had sent out information on the storage of high dose opiates in 2006, 2007, 2009 and 2011. We saw an email to staff in August 2014 which informed maternity staff that high dose opiates had now been separated and signposted in the controlled drug cupboard and book following a serious incident in which a woman had received 10 times the dose of diamorphine..

- The temperatures of drug fridges were not checked daily. For example in the birthing unit the fridge on five consecutive days was 9ºC, which was outside the recommended range of 2º- 8ºC. Therefore drugs being stored in the fridge had been consistently exposed to higher than recommended storage temperatures. There was no evidence of pharmacy advice being sought regarding the efficacy of drugs stored outside the recommended temperature. This issue had been identified in the 2011 medicines audit and also during a director's rounding on 21 December 2014. But this had not led to action being taken or follow up audits being undertaken.
- We identified a number of glucose bottles that had expired. We informed staff who removed these. We noted that there had been previous incidents recorded relating to the use of out of date drugs. In August 2014, following an incident in July 2014, staff were reminded by email to check dates before using drugs.

Records

- Records were easily accessible as women carried their pregnancy-related care notes in hand-held-records given to them at their first booking. They took the notes with them to all appointments both at the hospital and in the community.
- Record keeping for women during the antenatal period, labour and postnatal period fell below expected standards and at times was not in line with recommended practice for mothers after an emergency caesarean section. The paper and electronic records we reviewed showed that MEOWS were not consistently recorded, the frequency of observations were not documented and fluid balance charts were not always completed, resulting in observations being undertaken at random times, MEOWS score were not accurately calculated. We noted that one baby had their temperature first recorded 19 hours after birth.
- We were told that record keeping was reviewed at twice weekly meetings and at handovers and formed part of mandatory training. However, these checks had not impacted on record keeping standards.
- On return on the 23 March 2015 we observed that whilst MEOWS chart completion had improved, total scores were still not consistently recorded and the actual recording of respiratory rate and oxygen saturations was not recorded as a number, as directed on the chart.
- The 10 randomly selected notes of postnatal mothers who gave birth between August 2014 and March 2015 we reviewed showed that a handover of care form was not always completed, not all notes included MEOWS charts or fluid charts, or consent forms. Only a minority of records included evidence that complete sets of maternal observations had been recorded.
- The notes we reviewed demonstrated that daily baby observations were undertaken by staff working on night duty. The three sets of notes we reviewed showed baby observations were carried out between 05.30 and 06.00 with no further recordings in the daytime. Other observations were not always completed as directed. A baby who was assessed as needing hourly observations had these carried out at 03.00, 04.00, 06.00 and 09.00.
- Babies born following prolonged rupture of the membranes, meconium stained liquor and infants whose mothers were Group B Streptococcus positive and had received intravenous antibiotics in labour were considered to require additional observations. For these babies a new born observation chart was used, but this chart was not an early warning chart and although escalation was mentioned it was vague and not evidence based. Senior staff told us they did not use a neonatal early warning score (NEWS) chart but that one was being developed but there was no planned implementation date.
- Community midwives reported problems with remote IT access and printing and therefore had to keep some records on paper and enter the data later at home rather than during the working day. This led to delays in appointments and the giving of information to mothers.
- Not all personal information was stored securely. Notes of women currently on the postnatal patients were on an open trolley on the postnatal ward. There was a noticeboard on the postnatal ward wall that included information about each mother. As this was in a public area, the mother's identity was protected by the use of initials. However, the folder that contained the names that related to the mothers and contained information for the last 12 months was left in a public area opposite the board and was accessible to staff and members of the public. We also noted a document containing names and addresses of women who had home births was on a shelf in the birthing unit, easily accessible to unauthorised individuals, risking a breach of confidentiality.

- No record was kept of staff attending handover and the evening handover we observed, was delayed by ten minutes until there were enough staff present. Staff continued to arrive after the start of handover. There was no sharing of learning or of any other information other than the presentation of the woman on the ward that night. The only midwife to speak was the outgoing labour ward coordinator, and no midwives asked questions.
- We noted from the Maternity Risk Management minutes of January 2015 that patient notes should contain a risk assessment form to confirm that every woman had been assessed for the risk of VTE, as this assessment was often not completed. There was no evidence of a plan to improve compliance.
- Noticeboards in the handover room displayed out of date information, for example a memo from 2010 about Rhesus negative mothers, an operational policy dated November 2012 and a notice from August 2013 about the cost of sickness absence. Other signs were undated for example a blood spot testing notice about a procedural change that was 'Urgent, with immediate effect'.
- We noted supervisors of midwives had not undertaken recent record keeping audits.

Safeguarding

- The hospital's safeguarding policy had not been updated since 2012 and did not reflect the national government guidance from March 2013 about Working Together to Safeguard Children.
- There was a lead midwife for safeguarding, as well as a named midwife for safeguarding. These individuals provided advice and ensured there were multidisciplinary procedures for safeguarding and child protection concerns.
- Midwives we spoke with demonstrated a knowledge of the action to take and who to contact in the event of a safeguarding concern. We were told all midwives were trained to level 3 in safeguarding.
- The IT system flagged known vulnerable women to alert clinical staff to women who were admitted that there were existing safeguarding concerns. When women did not attend a booking appointment a midwife would make two attempts to contact them but if contact was not made, then the woman's notes were returned to medical records, and no further action taken.

Security

- The security to prevent unauthorised access to some areas of maternity was not effective with some receptions not always manned. We saw tailgating and the exit was not monitored as it was via a push button system so anyone could let a person in or take a baby out. There were no systems and processes in place to ensure babies could not be taken from the delivery suite or postnatal ward. We were not provided with an infant abduction policy.
- The hospital policy was that all babies should have two identity bands, one on their wrist and a second on their ankle containing information such as hospital number and date of birth. Staff told us that sometimes babies were transferred to the neonatal intensive care unit (NICU) with only one identity band. When this occurred the incidents were reported via the electronic incident reporting system. The risk register showed that the labelling system for mothers and babies was not compliant with the National Patient Safety Association (NPSA). A new system was to be implemented we were not told when.

Mandatory training

- The maternity training dashboard showed that the majority of midwives were up to date with mandatory training. However, the maternity care assistants did not take part in mandatory training with midwives and less than two thirds of these staff had completed infection control training and less than half had fire safety training.
- New doctors attend mandatory training as part of induction. Medical staff commented favourably on the quality and quantity of their education and training.
- Senior staff stated mandatory training was flexed to reflect training needs identified from incidents. For example, following the death of a woman though sepsis record keeping had been identified as needing improvement and mandatory training now included MEOWS.
- We were told that additional live simulation training took place in a purpose built room in the education centre. To date, two day-long sessions had been held that had been focused on the clinical learning from

recent SIs and developed by the lead obstetrician for the labour ward. Staff were selected by managers to attend, to date that was five obstetricians, a consultant midwife, matrons, junior medical and midwifery staff.

Assessing and responding to patient risk

- We were told that following the maternal deaths actions were being taken to improve the use of the modified early obstetric warning score (MEOWS) in order to detect deteriorating mothers. It was stated by senior staff that MEOWS was now part of all women's care. and junior doctors reported that the use of MEOWS was effective.
- Since the renewed emphasis on MEOWS in 2015, the chief nurse & director of governance had asked for an audit of MEOWS completion. This audit showed charts had been correctly completed in all but two cases. However we did not find this comparable standard of completion on our unannounced inspection three weeks after this audit had been carried out.
- Maternity care assistants carried out observations of mothers and we were told these were reported to the midwife. However, maternity care assistants we spoke with said they had no specific training on taking observations in a maternity setting if they had learnt this skill in another part of the hospital. There was no formal process for midwife review of observations of mothers and babies.
- We saw evidence in multiple occasions where MEOWS charts were not completed properly over a period of six months, including since the fifth maternal death. The protocol for monitoring women postnatal was not being consistently observed and not compliant with their own service standards for monitoring mothers.
- The recording of the neonatal early warning score was not taking place on this unit. Babies' temperatures were not routinely taken within an hour of birth, so there was no baseline from which to judge any change in a baby's condition. We were told that not all midwives had been trained in how to undertake an oxygen saturation reading on a new born baby and that training would take in place in the future to facilitate this.
- Delays in escalating concerns had been a theme of several serious incidents. Not all staff were familiar with the structured communication tool method Situation, Background, Assessment, Recommendation (SBAR) particularly in relation to handover of care. The need to extend training in the use of this tool was recognised and an action plan was in development. We saw no evidence of urgency about improving communication in times of concern, despite communication being a theme identified in the incidents reported.
- We were told by anaesthetists that the World Health Organisation (WHO) surgical safety checklist was in use. Its use was recorded on the hospital's electronic patient record. We were not provided with an audit of the WHO checklist.

Midwifery staffing

- Birthrate Plus, an established framework for maternity workforce planning had shown in October 2014 that a ratio of 1:26 was the appropriate staffing requirements given the acuity levels of mothers giving birth at this unit. At the time of our inspection the unit had a midwife to birth ratio of 1:30 in line with what was commissioned. However we were told that the staff to birth ratio was 1:28 if unqualified staff were included. The head of midwifery told us there were currently no plans to for the unit to comply with the Birthrate Plus recommendation of a 1: 26 ratio.
- There were specialised midwives for bereavement, haemoglobinopathy, antenatal screening, smoking cessation, mental health and infant feeding who provided mothers with specific support.
- The intention was that the band 7 labour ward coordinators were supernumerary. However, on half the shifts reviewed the coordinator was not supernumerary. This risk had been flagged as red on the maternity dashboard between June and December 2014 and there was no evidence of action to address.
- The obstetric assessment unit (OAU) was staffed by one midwife on each shift, sometimes with a student midwife, with an overlap of four hours between the early and the late shift. Staff reported that sometimes the unit was very busy and they did not get a break. We were told that if necessary staff would be moved from other areas if the staffing levels could not meet the needs of mothers attending.
- We were told that the required number of midwives on duty on the labour ward was 13 including the labour ward coordinator, this was to cover the 14 rooms on labour ward and also the birthing unit if they were required there. Staff said that these numbers were generally maintained and to ensure appropriate cover

midwives would be moved from the labour ward to the birthing unit if the two assigned midwives on this unit required assistance. Staff were also transferred from the antenatal ward at times of heightened activity.

- The labour ward coordinator told us the use of the National Patient Safety Association (NPSA) intrapartum toolkit to record staffing levels had recently been discontinued. She was not aware of any replacement for collecting this information. We were told that the completion of the toolkit had not been properly undertaken for a number of years which limited the validity of the data when the trust had been collating it and therefore a decision had been made to stop.
- On the 32 bedded postnatal ward there were five midwives in the day and four at night. In the daytime the fifth midwife managed mother and baby discharges.
- The antenatal ward had nine beds and two midwives. We were told that one midwife was often moved to the labour ward, leaving one midwife, often the most junior, on the antenatal ward.
- Some midwives told us the skill mix across the antenatal and postnatal wards was inconsistent and there were often more than 50% of staff on shift who had been qualified less than one year, and sometimes insufficient qualified staff. Staff also told us that they were often moved at night.
- We noted that there were usually agency staff on each shift. We were told that these staff were familiar with the hospital's guidelines and procedures. But in the January 2015 risk meeting minutes it was reported that agency and bank workers had no access to the trust guidelines.
- The challenges with staffing levels were not on the risk register, nor was an assessment of staff competencies. However we saw that a doctor had recently escalated this and suggested that staffing and skill mix should be added as a risk in relation to the delivery suite.
- We were told there were plans to draft experienced midwives into the hospital from the community and possibly stop staff rotation to consolidate experienced staff in the delivery unit, but we saw no evidence of progress on these plans.
- We were told that sickness levels were around 3% and vacancies about 2%. Staff could not explain why so many bank and agency staff were providing care as the vacancies and sickness rates were not the reason.
- Community midwives saw low risk mothers throughout the antenatal period in children's centres bring care closer to women's homes. An audit of women's experiences of the new community service was planned for May 2015. Women we spoke to welcomed having antenatal services near their homes and seemed happy with their antenatal care
- There were two multidisciplinary handovers daily at which all mothers on the labour ward were discussed and any specific issues handed over.

Medical staffing

- The Safer Childbirth London Safety Standards and Royal College of Obstetricians and Gynaecologists recommended consultant presence on the labour ward for a unit of this size, of 168 hours per week was not in place. Consultants' job plans had recently changed and their hours increased from 80 to 98 per week from February 2015.
- There were 12 consultant obstetricians and gynaecologists on the rota. A locum consultant was covering one vacancy pending a permanent appointment. The rostered consultants on-call at night were not routinely resident in the hospital although one consultant who lived a distance from the hospital stayed overnight when on call.
- The consultant on the labour ward was dedicated to the ward and did not undertake other work such as clinics during that day. Junior doctors spoke positively about the availability of consultants on the labour ward, including out of hours.
- The investigation of three of the maternal deaths had identified a link to the care the mother was given prior to her death including a lack of consultant involvement and delay in diagnosis. In response to this we were told that there was now an increased consultant presence on the postnatal ward with daily consultant led ward rounds taking place.
- There were two obstetric registrars on duty at all times including a senior registrar and a junior SHO on duty at night. A dedicated registrar covered triage and the obstetric assessment unit (OAU).
- There was 24 hour dedicated maternity anaesthetist cover for both elective and emergency caesareans, including obstetric consultant anaesthetist cover.
- Handovers were attended by incoming and outgoing doctors, obstetricians and anaesthetists, and midwives. The handover we saw was led by labour ward

coordinator, with input from the consultant on call. Following the multi professional handover the medical staff then had a separate handover which included gynaecology discussions.

- Locum doctors were frequently used. For example, from December 2014 to January 2015 three full time Registrar level locums had covered vacancies. In addition, during December, January and February locum SHO equivalents covered 23, 27 and 16 shifts respectively and 20. 12 and 17 registrar equivalent shifts.
- Medical trainees we spoke to told us that the hospital was a good place to train and gain experience. They spoke highly of the quality of care provided and the support they received from consultants.

Are maternity and gynaecology services effective?

Requires improvement

Women accessed the pain relief they needed and told us it met their needs. They were supported in looking after their babies and their own nutritional and hydration needs. Many of the clinical guidelines in use had been reviewed and were up to date.

However there was limited evidence that audits undertaken had led to improvements in practice. Mothers' outcomes were variable and in some cases worse than expected. There was limited evidence to demonstrate that appropriate action was being taken to address adverse outcomes. Not all staff had the skills and experience to deliver effective care, the unit relied heavily on a flexible workforce. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards was part of the safeguarding mandatory training. The majority of midwives did not understand their responsibilities in this area.

Evidence-based care and treatment

- The unit had an audit midwife who was responsible for ensuring national guidance was reviewed and mapped against the trust's existing policy. For example guidance from the national institute of health and care excellence (NICE) or the Royal College of Obstetricians and Gynaecologists (RCOG). Some of the policies and guidelines we reviewed had been updated to reflect national guidance.
- The maternity clinical audit plan for 2013-2015, included 56 audits. Not all audits had an identified lead and responsible supervisor and only15audits stated the time period the audit was expected to cover. The audit plan had columns to record whether this was a re-audit, expected completion dates, reminder dates and the date the audit had been presented, but, these columns had not been completed. The head of midwifery assured us that we had been provided with the most up to date version of the plan.
- It was unclear which audits had commenced as there was no column to record the start date or whether the audit had commenced. Where the data gathering dates had been recorded, these were at least 12 months prior to our inspection. The audit plan did not state whether individual audits were linked to national or local priorities.
- An audit of 41 women had been carried out on drug allergy administration in early 2015 in response to a medication incident where a woman had been prescribed penicillin to which she was allergic. Women now wore a wristband and a sticker placed in their notes if they had a drug allergy. The audit found not all women had been given the correct wrist band and a sticker had not always been placed in their notes. It was recommended staff were reminded again through "Tips of the Fortnight" although this had not happened. There was no recommendation for a re-audit or that any other action had been taken to minimise this risk.
- An audit presentation on postnatal ward antibiotics was provided; the audit was not dated although made reference to 2012 guidance. The audit was not listed on the clinical audit plan.
- We were provided with the action plan developed following an audit of massive obstetric haemorrhage. We asked for but were not provided with a copy of the original audit. The action plan stated the findings had been presented at the multidisciplinary meeting in December 2014 and that all actions had been implemented. There had been considerable delay in presenting the audit findings as audit had taken place prior to March 2014.
- The other three pieces of evidence of audit provided included an undated audit, the second was raw data only and the third related to an audit undertaken in 2012.
- Only one of the audit action plans provided was listed on the clinical audit plan. Despite us requesting two

completed audits from the current audit plan, detailing action taken, evidence of the minutes where the audit was presented as well as evidence of implementation this was not provided.
- Risks identified through the audit process were not included on the maternity department's risk register.
- The maternity dashboard demonstrated that there had been a 11 cases of sepsis in December 2014. The head of midwifery told us she did not know if there had been an audit or investigation into this and that we should refer to the lead obstetrician. We requested a copy of any investigation undertaken in response but this was not provided.
- Mothers who attended the unit for assessment because they were in labour or concerned about their or the baby's health were initially assessed by a triage midwife. We were told the trust had standards that women being seen in triage should be assessed by a midwife within 15 minutes of arrival to ensure that any clinical risks were identified and escalated promptly. But we were informed that there was no monitoring of adherence to this standard to ensure that women were being assessed within the trust's internal standard.
- The maternity dashboard reported that 100% of women had received one to one care during established labour. It is unclear how the service were monitoring 1-1 care in labour as the use of the NPSA scorecard was no longer in use and mothers were not specifically asked their views on this. Staff could not readily articulate how the 1-1 care was being assessed or calculated.
- NICE guidance recommends that perineal repair should take place as soon as possible post-delivery but we noted in the risk meeting minutes many delays in suturing of greater than 90 minutes had occurred and had not been documented in patient notes. Therefore the data on the maternity dashboard did not reflect the level of risk to women from infection and blood loss. The "risky business" newsletter for February 2015 reported that only 66% of perineal repairs were repaired within an hour but we did not hear of or see a plan to improve this.
- The guidance for maternal collapse was included within the MEOWS chart and recognition and care of the severely ill woman guideline (2013). However there was no specific maternal collapse policy.

Pain relief

- The midwives we spoke with told us that women were able to access pain relief as required including an epidural if requested and clinically appropriate.
- The maternity department had two dedicated anaesthetists which meant unless there were two women in surgery a second anaesthetist was available to provide the women with an epidural.
- The women we spoke with all told us that they were given adequate pain relief during their labour and in the postnatal period.

Nutrition and hydration

- Women we spoke with were satisfied that their own nutrition and hydration needs had been met. However the staff we spoke with told us that if women had arrived on the postnatal ward after meal orders had been taken that the catering staff did not provide them with a hot meal. Midwives arranged a sandwich for these women.
- Mothers were encouraged by midwives and support workers to breastfeed their babies. Women who chose to bottle feed were required to bring their own bottles and formula milk and had access to a milk kitchen was provided. Emergency bottles of baby milk were available.

Patient outcomes

- The maternity department maintained a quality and performance dashboard which reported on activity and clinical outcomes.
- The maternity dashboard for January 2014 to December 2014 indicated that the target of 90% of women referred and booked by 12 weeks 6 days had been met. However the overall percentage of women who had booked by 12 weeks 6 days which included women who presented beyond 12 weeks was lower and on average was between 60-65%. We were told that this was because some GPs did not always make referrals and were advising women to self-refer and that a high number of Jewish women lived in the community who did not make their booking for religious reasons.
- The number of women who suffered severe postpartum haemorrhage (PPH), a blood loss during or immediately after birth of more than two litres was high. The trust set themselves a target of less than 20 cases per 1,000 deliveries, compared to a national average of 5.8 per 1,000. The trust performance from July to September 2014 was 12, 10 and 17.5 cases per 1,000.

Maternity and gynaecology

- For the same months the number of 3rd and 4th degree tears was 16, 9 and 16 against a target of less than 7 cases each month.
- Approximately 40% of women had a normal delivery without any form of intervention which was fewer than the national average. We were told no action had been taken to improve normal deliveries to date as the trust were awaiting data from the wider London group to assesses whether they were an outlier. The national average for women delivering in a co-located birthing centre was 20%, the trust achieved 15%.
- Caesarean sections, both elective and emergency were high and averaged around 30% throughout the year, The maternity department were an outlier for the high number of emergency caesareans, an action plan had been developed and it was reported that most actions had been completed. However, improvements had not been observed and we were not informed of further or additional actions that were being considered.
- The information on the dashboard for emergency caesareans averaged 22% over the previous seven months with peaks to just under 25% in August and September 2014, which is above the expected emergency caesarean rate of 15%. The dashboard did not have a target set for emergency caesarean sections despite the trust having been identified as an outlier in 2014. Targets had been set for the total number of caesareans only.
- The trust's target was to have less than 12 maternal readmissions with greater than 17 flagged as red. These figures were based on an estimated delivery rate of between 560 and 600 per month, we noted that during the month of August 2014 the number of deliveries was 505, and there had been 16 maternal readmissions this month which was flagged as amber and not red.
- Babies experiencing meconium aspiration and hypoxic encephalopathy exceeded the trust's internal target in some months.
- The trust had set a target no more than 50 unexpected admissions of babies to SCBU and NICU which equated to just over 8% (based on 600 births). The NHS Outcomes Framework 2014/15 standard for these unexpected admissions is 6.1 %.
- We were provided with an audit presentation on the number of unexpected admissions to NICU and SCBU, however, it was unclear what the objectives or conclusions were from the presentation provided.
- The number of women who developed eclampsia each month was not reported on the maternity dashboard. However a review of eclampsia had been carried out from March 2014 to February 2015. The review showed no women were categorised as 'eclampsia' during the time period stated. An audit of pre-eclampsia had been completed the year before.
- We were told by members of the management team that performance was worse than the England average for some targets because of the clinical complexity of women attending the unit, for example the number of women with diabetes or with a high BMI was reportedly higher than the national average.

Competent staff

- It was the perception of the senior staff we spoke with that staff working in the maternity department were competent and viewed the unit as strong with a cohesive team that worked hard, but there was a lack of internal and external challenge.Staff told us that the main areas for improvement for the team were more challenge and scrutiny.
- The staff we spoke with all told us that they had received their annual appraisal and supervision and that they found this process helpful. We saw that at 17 March 2015, 76% of midwifery staff and 80% of medical staff had completed their appraisal, below the trust's target of 90%.
- During 2014 the supervisor to midwife ratio was 1:18.5; the national average is 1:15. We were told that a midwife with a full time supervisory role had been appointed in January 2015 which had assisted in reducing the ratio to 1:9. The LSA report commented that just under 90% of midwives had completed their supervision.
- Some midwives we spoke with told us that the skill mix on most shifts was an issue as there were a high number of midwives qualified less than one year who needed support and were unable to perform some basic tasks such as suturing or cannulation. It was also reported that some shifts had a very high number of agency midwives.
- We were told that a small number of midwives were trained to undertake the examination of the new born baby. We reviewed shifts over a three week period and saw that on average five out seven shifts per week had

only one midwife who was trained to undertake baby checks. We were told that this was not an issue as there was paediatric presence in the department to undertake these checks.

- To ensure all midwives maintained their competencies the trust had implemented a 'rotation' rota for midwives. There was a core group of midwives who remained working in a specific area of maternity. Other midwives rotated between community, antenatal, labour ward and postnatal ward, we were told that rotation for hospital areas lasted approximately eight months and that this was longer for community midwives, around 18 months.
- The details of the rotation timetable provided related to rotations which had taken place in March, September and October 2014 when 14, five and one member of staff had been rotated respectively. It was unclear from the data provided how long rotations had lasted or whether staff had been rotated more recently.
- Midwives had assistance from support workers at band 2 and band 3 level. One of the responsibilities of band 2 support workers was to undertake observations of mothers and babies. Midwives stated if these observations were outside of the expected range they would alert a midwife. The MEOWS and care of the severely ill woman policy identified the observations appropriate for maternity care assistants to undertake.
- All midwifery support workers were expected to complete a competency based booklet and submit this to the practice development team. Support workers were responsible for ensuring their competency booklet had been completed and submitted. The practice development team showed us examples of completed booklets, however, the department did not maintain a list of all support workers and reliance was placed on the support worker to ensure the competency booklet had been completed. The team were therefore unaware of those who had not completed their own competency checks.
- Emergency practice simulations had taken place on seven separate occasions in 2015. These covered a range of scenarios, postnatal sepsis, pre-eclampsia. Learning points had been recorded, we were told that learning was fed back to the midwives involved and that there was no wider learning for other staff working in the unit. Junior doctors reported that these were important learning opportunities , but midwives we spoke with told us that they had not been involved in an emergency simulation for over one year but that they had found these helpful in the past.
- Theatre staff provide a recovery nurse to care for the mother post operatively, as it was stated the midwife was there for the mother. However, the recovery staff have not received any specific training in caring for maternity patients.
- The midwives and ward managers working on labour ward that we spoke with told us that room 5 on labour ward was a High Dependency Unit (HDU) and up to two women could be cared for in room 5. This was not a confirmed by the head of midwifery who stated that there was not an HDU room in labour ward. We were told by midwives that women in room 5 required HDU level care and that wherever possible midwives with a nursing background would care for women in room 5. We were told that none of the midwives had been provided with recovery or HDU training.
- We were told that all staff have been trained on how to use the machine and interpret the CTG. We were told that a 100% pass rate has been achieved in on-line CTG training (K2). However, we also saw through review of serious incidents that in some cases, the CTG had had not been interpreted correctly. We asked how the effectiveness of CTG training was monitored but there had been no monitoring or audits of the effectiveness of the CTG training provided.
- The patient safety minutes from May 2014 reported on findings from an investigation following an intrauterine death. A query was raised about the midwife's training and if this was out of date at the time of incident, however, no one present could answer this question and no further questions were asked or data requested to confirm the midwife's training status.
- The investigation report for another serious incident reported that he skill mix in theatre had contributed to the adverse event as the midwife caring for the patient was a junior "preceptorship midwife" being assisted by a student midwife. Neither had previously been involved in an instrumental delivery in theatre.
- An undated presentation of the survey findings of midwives understanding of epidurals stated there was no evidence of robust testing of competencies. The recommendation from this to improve patient safety and satisfaction during the use of epidural in labour was for a standard introductory module for all midwives.

- We were told that all staff who led on investigations into serious incidents or never events had completed root cause analysis (RCA) training provided by an internal team. We were not provided with evidence of the content of this training or who had attended. Senior management stated they had tried to source external RCA training but have been unable to find suitable provider. This was a weakness which had been identified in the 2012 Deanery report, action had still not been taken.
- There were no checks on the competencies of agency staff, despite some shifts having a high proportion of midwives from an agency. When presenting for duty a midwife's intention to practice was checked as being entered on the LSA database by the supervisor on call . We were told there was an on-going audit of the induction of agency staff. Agency and bank workers both doctors and midwives had no access to maternity guidelines. Although we saw that locum and agency staff (midwifery and obstetric) should demonstrate completion of K2 training, it was not clear how temporary staff were to be trained..
- In response to the maternal death in 2013 which had involved a difficult caesarean section, more complex elective caesareans were now carried out on a set day when experienced obstetric staff were present. The investigation of this death had also highlighted the need for more training for theatre staff in a specific piece of equipment. As of April 2015, this training was not fully in place and not all staff had completed it.

Multidisciplinary working

- The staff we spoke with reported good multidisciplinary (MDT) working both internally and externally. Staff reported that medical and midwifery staff worked well together most of the time.
- We were told that external arrangements also worked well and that information was regularly received from social services regarding individuals specifying any support they may be receiving or may need.
- We were told and saw that safeguarding and domestic violence concerns were discussed at the weekly psychosocial meeting to consider the action which had been taken and whether this was appropriate.

Seven-day services

- Maternity services were available 24 hours a day seven days a week. All women could access maternity care in an emergency through A&E or the maternity reception.
- An ultrasound machine was available on the labour ward which could be used out of hours if necessary.
- Arrangements were in place for pharmacy cover during the day and we were told that the pharmacy service were available out of hours using the on-call system if necessary.
- A maternity helpline was available from 10.00 am to 6.00pm daily which was staffed by experience midwives. This number was given to all women were in addition to the number for their own midwife.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that the Safeguarding training included a section on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. However, the majority of midwives we spoke with did not understand the MCA and what their responsibilities were or what was meant by mental capacity.
- When asked about the MCA most staff explained about mental health issues and the need for psychiatric involvement. It was expected that such issues were identified in the community and that if issues arose during a hospital attendance that a referral would still be made to the psychiatric team.
- We were told that consent was gained from the mother prior to procedures or surgery taking place. Verbal consent was obtained for examinations and written consent for surgical procedures, except in the case of medical emergencies. The patients we spoke with told us consent had been requested and this was supported by evidence in patient notes.
- For those women who experienced foetal abnormalities, the counsellors in the foetal medicine unit were available to explain implications of conditions or abnormalities and refer them to external organisations for advice such as to the charity for Antenatal Results and Choices (ARC). We were told women who chose a termination were made aware of the options for the disposal of their pregnancy remains but staff were not able to show us how a woman's consent to disposal was be recorded in her medical notes.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

The women and their partners who we spoke with on inspection were mostly positive about the care they had received. Overall responses to the friends and family test showed women were happy with the care they received throughout their pregnancy. However the response rate was very low and it was not evidenced that alternative feedback mechanisms were being used. Overall women understood and were involved in their care and received the emotional support they needed.

Compassionate care

- Most mothers and their partners we spoke with on inspection were positive about the care they had received.
- A number of people had shared on NHS choices that they had considerable waits and were not communicated with as they had expected when using the service.
- On a number of occasions we noted limited interactions between staff and mothers (and their partners) on the postnatal ward, these only took place during specific tasks such as during routine baby checks.
- The results of the last CQC National Maternity Survey (2013) found that the trust was among the worst performing trusts in all three sections of labour and birth, staff and care in hospital after the birth. An action plan had not been developed to address the performance. The midwives we spoke with were unaware of the findings of this survey and could not describe any actions that had been taken to address the poor outcomes, specifically in relation to compassionate care.
- Responses to the maternity services Friends and Family Test (FFT) were overall positive. Women were happy with their care and the attention they received. However the results were not displayed and the response rate was between 6% to 9% July to August 2014, less than the national average. Some staff we spoke with were unclear what the FFT was and thought it was about staff not patient views. They thought patient feedback was generally good but were unclear of the any specific feedback. We were told that to increase the response rate the trust were exploring the use of volunteers to collect mothers' views but there was no date for this to commence. We were also told that tablets had been introduced but some mothers did not want to use these. Midwives also stated that feedback cards were being used and that they were recording direct feedback from mothers and their partners. However, we asked for evidence of the findings from these alternative feedback mechanisms but we were not provided with this evidence.
- We observed that on the labour ward there was a board with 'you said - we did' stating changes that had been undertaken in response to feedback. There were three changes detailed on this board. It was unclear when these changes had taken place as there was no date and staff were unaware of when the changes had taken place.

Understanding and involvement of women and those close to them

- To prepare mothers and their partners for the birth of their baby ward tours took place weekly in the early evenings, midwives familiarised women and their partners with the environment and were available to answer any questions.
- Women we spoke with said they had been given a range of information and were clear about their birth plans and had been given explanations about their treatment.
- Partners we spoke with said that they felt able to ask questions and were given answers that reassured them. However, one father stated his partner's wish for the curtains to be closed around her bed so she could sleep had been refused; he was unclear why staff had not allowed this. Staff we spoke with explained that this was due to the need for the mother to be closely observed. However, they could not explain why this reason had been shared with the mother or her partner.
- Mothers discharged from the OAU were provided with information about the signs and symptoms they should look for and if they experienced these they should return to hospital.

Emotional support

- Most staff we spoke with considered that when a maternal or baby death occurred it was dealt with in a compassionate, professional manner and that support was provided to parents, relatives and staff. Two part time bereavement midwives to offer women support when they had stillborn babies.

- Counselling was available to women when abnormalities were identified. For those women who did not speak English this was provided with the support of an advocate who was able to translate.
- We were told that a multi-faith chaplaincy service was available to provide support to mothers, their partners and family.

Are maternity and gynaecology services responsive?

Good

Staff were aware of the demographics of their local population including the numbers of women living in temporary housing and acknowledged in some cases the lack of timely access to maternity care. The service was responsive to the needs of established ethnic minority groups. The local population is ethnically diverse and family members were often used to interpret. Women had a named midwife and were provided with their mobile telephone number when they initially booked to use the maternity service. The service provided continuity of care to at least 70% of women during pregnancy and the postnatal period.

Many complaints were not responded to within the trust's target of 25 days and there was limited evidence of learning form complaints.

Service planning and delivery to meet the needs of local people

- The delivery unit had not been closed in the last calendar year. The delivery unit was reported to be often on amber alert. A senior midwife said that the escalation plan and what the amber status meant was unclear. We were told when on amber the midwifery managers should assist on the delivery unit rather than escalate the risk.
- The service may close the maternity unit at any given time if the clinical view is that demand levels are compromising safety. The unit closed to admissions one on occasion in the last two years for a period of 43 hours. The service may also cap the numbers of new bookings for delivery accepted if the forward view predicts births to be above 540 in any given month. The cap would applied to those women considered to be out of the core commissioning areas. Bookings have not been capped since February 2014.
- The antenatal clinic area had recently been refurbished to improve facilities. This area was also used for clinics for new born babies requiring minor procedures such as release of tongue ties.
- We observed that rooms in the birthing unit were spacious with a range of equipment such as birthing balls, birthing couch and hanging ropes to promote women being active in labour and helping them have a normal birth without any intervention.
- Midwives stated a range of care pathways were used to ensure a mother's needs were met. These included specific pathways for women with sickle cell, diabetes and for mothers who were clinically obese. There were also care pathways to meet the needs of mothers known to have mental health conditions, with a history of substance misuse and homeless mothers needs.
- The hospital delivered maternity services to women who spoke a wide range of languages. There was no trust guidance on the use of professional advocacy or interpreting services. The flowchart provided by the trust's advocacy department stated that the first option was to use friends and family, but not children, to provide language support for their relative.
- Interpreters were employed who spoke 21 languages, some of whom were on site Monday to Friday, for example Turkish and Bengali speakers. Interpreters for other languages could be booked through two external interpreting agencies, but required 48 hours' notice which in an emergency did not meet the mothers. There was also access to a 24 hours a day telephone interpreting service.
- Bilingual maternity support workers were employed in the community who were available Monday to Friday 08.00am to 4.00pm to provide advocacy support both in the community. The support workers spoke nine languages between them which covered some of the languages spoken in the local population.
- We were told that actions were being taken to improve access to advocacy or interpreting services and new standards and guidance was being developed to include more mobile telephones being available to access interpreters and arrangements were being made for interpreters to attend booking clinics, when women

first met the midwives. The patient safety committee minutes of January 2015, highlighted an issue of interpreters not being available at weekends. A member of the group had been asked to investigate out of hours support. We were not provided with an update of the progress made to improve out of hours support.

- Only a few midwives we spoke with were aware of the planned changes and many stated that if the woman were agreeable a family member would be used to interpret. We were also told that if it was not possible to obtain an interpreter or advocate the midwife would try to communicate with the mother using hand gestures. We did not see and were not provided with any plans to ensure that the interpretation and advocacy services were used appropriately.
- Maternity services delivered care to a number of high risk mothers, for example those experiencing complication in their pregnancy. These mothers were discussed weekly at the foetal medicine meeting attended by the obstetricians and neonatal intensive care consultants to identify the additional resources required during the woman's labour and post-delivery such as neonatal care for the baby.
- The CCG sponsor had recognised that the MSLC needed to increase the range of women involved in maternity service development and delivery and strengthen their role. A new tender had been issued with the aim of providing a service to support the MSLC to give women a stronger voice in improving services and provide a qualitative perspective in the monitoring and evaluation of services. The new provider was due to start in June 2015.

Access and flow

- All women living in the local area could access the maternity services either by referring by telephone or completing an online form, or could be referred by their GP.
- The recording and reporting of women booked and attending their first appointment within 12 weeks and six days should be counted once the woman has had their first assessment by a midwife. We were told by staff that first full booking appointments were not always used to calculate this and if the woman had attended a scan and had their blood taken before their first appointment, the earlier date was used.
- We were told that as of October 2014, women had their scans and blood tests done at the hospital. However, low risk women, those with no serious health conditions, pregnancy-related or otherwise had their initial booking appointment, their first meeting with the midwives, and subsequent care delivered by the community midwives in the local community setting. These clinics were held in children's centres and health centres and reducing the need for mothers to travel to the hospital.
- For those women considered high risk, such as older mothers or those with known pregnancy-related or other health conditions requiring increased monitoring their care was consultant led care and was provided from the hospital setting.
- Mothers experiencing pregnancy-related concerns could access the obstetric assessment unit (OAU) either by self-referring or through referral from the antenatal clinics and community midwives. We noted from the records that between eight and 28 mothers might attend in a 12 hour period. Staff told us that when demand for the service could not be met by the staff on duty they would request support from the labour or postnatal wards. But it was not always possible and this resulted in women experiencing long waits to be assessed.
- We were told there was no overview of activity in OAU, the antenatal ward and delivery suite to prioritise bed usage and improve the flow of women through the service.

Access to information

- The trust website provided a number of links to information such as a parent craft class timetable but no timetable was available via this link. There was also a link to information about how the hospital supported women breastfeeding and 12 downloadable leaflets related to pregnancy, but only in English.
- We saw a range of leaflets about home birth, the birth centre and induction of labour, some which were photocopies were available in the antenatal clinic but were only in English. While in the delivery suite there was information about epidurals in over 30 languages, which we were told met the needs of the majority of women. There was no information displayed about how to access translation services, or obtain leaflets in other languages.

- The foetal medicine unit had information about relevant topics including birth abnormalities and counselling services. This information was only in English but we were told an advocate would be used for those women who did not speak English.

Meeting people's individual needs

- Women had a named midwife and were provided with their mobile telephone number when they initially booked to use the maternity service. We were told the service aimed to provide continuity of care to at least 70% of women during pregnancy and the postnatal period. We saw evidence that this target was being achieved, although we were told that on occasion there had been delays in arranging women's booking appointments.
- Midwives said women were encouraged to make a choice about how their pregnancy and the birth was managed; however there was evidence that this was not always the case. For example, some women wanted a home birth even after being informed of the risks. We were told that not all midwives and consultants would be an advocate for these women and support their choice and assist in managing the risks. There was guidance and processes in place for those women who request a homebirth outside the realms of normality.
- Midwives were not always fully included in the discussion between the consultant and the mother when risks were being discussed. Therefore some midwives were unable to fully support or answer the mother's queries after that consultations consultation.
- The investigation into a maternal death in 2013 found that language had been a potential contributing factor. In response an audit of women's notes to assess if the need and use of interpreting services was documented had been undertaken in March 2015. This audit found that the documentation of the use of interpreters was poor and that midwives generally relied on family members to interpret.
- A significant number of Orthodox Jewish women use the maternity services. The hospital had developed good relations with this community through a bi-annual meeting at which issues and ways to improve their experience were discussed. Changes made included piloting volunteers from the Orthodox Jewish community to encourage earlier booking for maternity services as culturally this group of women prefer not to inform people of their pregnancy until the fourth month.
- Staff had access to information to assist them to meet the specific religious needs of mothers. For example there were specific arrangements agreed between the hospital and the Jewish religious leaders about discharge of women before nightfall on holy days. There was also information for staff about the needs of the Muslim communities.
- Following a pilot of allowing partners to stay overnight on the postnatal ward, this initiative had been implemented. Partners staying overnight slept in chairs at the bedside. Staff we spoke with stated that since the introduction there had been no concerns or complaints.
- To support mothers who wished to breastfeed, the service was piloting breast feeding volunteers and was working towards obtaining UNICEF baby friendly certificate of commitment and level 1 accreditation.
- We were told over 40 midwives had completed additional enhanced breast feeding training by January 2015. However, we were not provided with information about breast feeding rates and the impact of this training had on increasing breastfeeding.
- The Foetal Medicine Unit and scanning unit was in newly refurbished area with a spacious waiting area with a television screen. The environment was designed to be calm and there were several private rooms for counselling women.

Learning from complaints and concerns

- Information about how to raise a concern or make a complaint was available in clinical areas. This information was available in English, Vietnamese, Polish, Bengali and Turkish. We were told that all complaints and compliments received by the Patient Advice and Liaison Service (PALS) were forwarded to the maternity service and discussed at the CLIP before being assigned to an individual member of staff to investigate. As the these meetings were not minuted, there was no audit trail of who had been assigned a specific complaint and when to monitor progress.to deal with.
- We noted 49 formal complaints had been received during the period January 2014 to February 2015,18 were about inadequate treatment. Other significant themes were about information, mothers having to wait for assistance and staff attitude. Most midwives we spoke with were unaware of the main themes of complaints.

Maternity and gynaecology

- Minutes of the February 2015 trust board meeting reported that complaint response times continued to decline in all services. We were not provided with a rationale for this declining performance or any actions that were being taken to address the issue.
- We were told that changes had been made in response to complaints. These included the reception area outside labour ward being improved with a triage midwife now responsible for mothers in the waiting area. New guidelines being produced for the latent phase of labour and the use of the pain relief Oramorph.
- The formerly quarterly publication called 'Risky Business' was now to be issued monthly. The February 2015 issue included a summary of the two maternal deaths which occurred in 2013.The effectiveness of this publication had not been evaluated, however senior staff referred to this and "Tips of the Fortnight" frequently as the means by which communication and learning took place.

Are maternity and gynaecology services well-led?

Requires improvement

The vision and strategy for maternity services was not documented or fully understood by staff. The unit had identified leader at both board and unit level. At ward level, staff felt supported by the matron and ward sisters.

Performance data was unreliable and not used to identify poor performance and areas for improvement. The risk register did not include many key risks as they had not been identified and therefore there were no mitigating actions to reduce these risks.

Action plans were reviewed individually with no overview of the common actions or issues identified. There was a lack of challenge among staff and poor standards and performance was not routinely questioned. Limited action had been taken to engage with mothers and their partners.

Vision and strategy for this service

- Senior staff told us the vision was to grow the service in response to the increasing population. However, many staff we spoke with were unaware of this and it was not documented.
- There were four local objectives set by the department which included delivering safe and effective maternity services, integration of IT systems, to increase capacity through redevelopment and to review the effectiveness of the recent reconfiguration. Each objective had been assigned to a named individual and there were measurable outcomes and milestones recorded. But limited detail of how they would be achieved or proposed costing for the three objectives which required funding.

Governance, risk management and quality measurement

- We requested a copy of the trust's committee structure which demonstrated the lines of reporting for all committees and groups this was not provided.
- The reviews of maternity SIs were managed through the patient safety committee. The head of midwifery, risk midwife and risk consultant met weekly to review incidents and reported to the patent safety committee. We saw evidence of some discussion being recorded, findings were not always questioned or followed up, for example when a question was asked about the completion of mandatory training by a midwife involved in an incident. It was stated this information was not known but there was no challenge to this or follow up.
- We were told that the main meeting for maternity services was the maternity risk management meeting (MRMR) which discussed a range of topics including incidents, the risk register and maternity dashboard and received reports such as divisional complaints. It reported to the trust wide patient safety committee, the main forum for discussing SIs
- The trust wide patient safety committee minutes for January 2015, demonstrated that SIs from across the trust were presented and discussed.
- We were told the maternity dashboard was presented at the patient safety committee and at the monthly ward sisters' and matrons' meetings. Minutes of this meeting recorded the discussions about some areas of underperformance, for example, first booking, the number of caesarean sections and consideration being given to reporting 3rd and 4th degree tears separately. On-going poor performance in other areas such as the high number of incidents of meconium aspiration was not discussed. Ward sisters we spoke with were unaware of the areas of poor performance on the dashboard.

- Senior staff in the trust stated that they considered there to be no inherent fundamental risks in the maternity service and that there was no required learning from the recent published national maternity report.
- The local objective, to ensure delivery of a safe and effective maternity department was recorded as needing to be included on the risk register, however, we noted this was not on the maternity department's risk register at the time of inspection.
- There was limited discussion about clinical outcomes which were flagged as red or amber. For example the issue of puerperal sepsis had been discussed and the majority of actions had been implemented. There was no consideration of the effectiveness of the actions and that had been area of poor performance since February 2014.
- The number of preterm stillbirths was reported to be higher than expected between July and October 2014 and again between January and March 2015. The number of preterm stillbirths had been sporadically high throughout 2014. However, possible underlying causes had not been investigated.
- The trust's emergency caesarean section rates in 2014 were considered to bean outlier, the maternity dashboard reported that these rates remained high. In February 2015 minutes of the patient safety committee noted the on-going variation in caesarean rates but did not state what actions were being taken.
- We were told that the medical director and the chief nurse, director of clinical governance met with each of the divisions monthly. Maternity was part of the surgical division and maternity services were discussed as part of the 90 minutes meeting held each month. The meetings included focus on specific issues, including new risks, workforce and activity.
- There was a quarterly business planning meeting chaired by the CEO that focused on quality and reviewed feedback from the divisions. The CEO was confident the group was achieving its aim but recognised there was a need to relook at implementing triggers if a division was not achieving actions. Currently the chief nurse, director of governance updated the CEO on actions not being delivered or embedded.
- Risks were escalated to the maternity risk register following a review of any new or emerging risks by the patient safety committee, who made the decision the risk should be added to the register. However, key risks such as poor outcomes for women reported on the maternity dashboard had not been recorded as a risk.
- We were told the contributing factors to the five maternal deaths during the preceding 18 months had been recorded on the risk register and removed when action had been taken. However, we found evidence that action was not always consistently applied despite the seriousness of the incidents, for example MEOWS charts were still not being completed in line with requirements.
- There were nine maternity risks on the register which related to wristbands, antenatal and new-born screening as well as community appointments. Each risk had been scored and mitigating actions taken recorded. Risks had not been not been assigned to an individual and some actions required were overdue. All risks with a score of 12 or more were reported to the trust management board and included in the trust Board Assurance Framework. There were currently no risks scored above nine.
- All five maternal deaths had been or were in progress of being investigated and action plans developed. Investigations looked at individual deaths and there had been no mapping of the deaths, to consider whether time of day, day of the week, staff involved, agency/ locum usage, number of staff on duty, equipment used or other factors had been a consideration of potential impact. While it was noted that the action plans developed had elements of crossover they had not been merged to form one unified action plan.
- The evidence provided to demonstrate that the maternity action plan was implemented showed that there was limited governance and oversight to assure the identified local leads and executives for specific actions had implemented their actions and that these had been effective in addressing the issues. Staff told us that they thought most issues had been addressed but no evaluation on their effectiveness had taken place.
- We were told that because there were numerous action plans there was not enough time for them to all be reviewed at the risk committee and therefore the risk midwife was tasked with following these up and the head of midwifery stepped in if there was slippage.

Leadership of the service

- The service was managed by the divisional operations director. The head of midwifery was directly line managed by the divisional operations director with a line of accountability to the chief nurse and director of governance.
- Department level leadership was provided by the two matrons, one responsible for inpatient services and another responsible for outpatient services. As well as ward managers / shift leaders for each area within the department.
- Visibility of medical staff was variable. Staff told us some of the 12 obstetric consultants were more visible than others, but medical trainees praised the support they received from consultants.
- Medical trainees also commented favourably on the visibility and leadership style of the chief executive in the maternity unit.
- The midwives we spoke with all reported that they felt supported by their immediate line management and that they had good working relationships with all staff groups. However some commented that they rarely saw their senior management and that when the department was busy and support was needed, midwives with a non-clinical role and managers did not 'step-in' to support them. Some of the midwives who worked on antenatal ward did not always feel listened to when they escalated concerns about women who needed to be transferred to labour ward.
- When we asked executives and service level managers about the high number of sepsis cases which had occurred in December 2014 and the action taken, we were told that this would be the responsibility of an obstetrician to look into this, no one we spoke to could inform us of any actions that had been taken. Senior managers were unable to provide us with the outcome of the MEOWS audit and directed us to the audit midwife for this detail.
- We were informed by the head of midwifery that there was no action plan in response to the CQC National Maternity Survey of women's experiences published in December 2013 and that concerns raised had not been revisited. The action plan we received did not cover all areas where the service was assessed as worse than other trusts and did not focus on areas where the views of mothers had deteriorated since the last maternity survey. The plan focussed on the constraints the service was experiencing rather than the views expressed by the mothers in their responses. It was presented as a completed action plan despite the completion dates having passed. We were not informed how the delivering of the actions had been monitored and evaluated.
- Shift leaders did not always take responsibility for their area. For example when we identified environment and equipment issues and highlighted these to the shift leader their response was slow, they did not take responsibility but apportioned blame to support workers and demonstrated limited or no knowledge of why the issues identified needed to be addressed urgently.

Culture of the service

- The trust performed well in the 2014 maternity staff survey scoring significantly better than average for 13 questions, average for 74 questions and worse than average for 5 questions.
- The maternity service scored significantly better than average for staff feeling informed about errors and being given feedback about the investigation of errors. Staff were significantly more likely than average to feel confident that the trust would address concerns about unsafe clinical practice.
- Staff were more likely to recommend the maternity service as a place to work than average and more likely to feel that senior staff were committed to patient care.
- Staff we spoke with felt able to raise concerns and were aware of the trust's whistle blowing policy.
- The staff we spoke with were aware of a group called "the unhappy midwives". The "unhappy midwives" raised concerns to the trust and commissioners anonymously on a regular basis. The view of staff was that if they wished to raise concerns they had a professional duty to do so, not anonymously. Staff reported that if they had been named in communication sent in by these midwives the trust were supportive towards them.
- Many midwives spoke positively about their relationship with the consultants. Some staff reported that there were known difficulties within the department and that some consultant's behaviour was not always appropriate but this was a long standing problem and was tolerated by midwives.

- We were told that following each maternal death an e-mail had been sent to individuals involved offering support of counselling if required. We were told that those directly involved were given a verbal debrief after the event and a subsequent offer of support.

Public and staff engagement

- We were told that the trust engages with women using the service through surveys such as the Friends and Family Test and complaints received. We were not told of any plans to improve response rates of the Friend and Family Test and we were told that staff were, "at a loss as to what to do".
- The results of the 2013 national maternity survey, undertaken every three years, reported that mothers had expressed concerns about infant feeding, the trust not being baby friendly and not encouraging skin to skin contact. They also raised concerns about the dignity and respect of mothers, and cleanliness of bathrooms and toilets. In response to this survey the maternity services liaison committee (MSLC) reviewed the results and contributed to the development of an action plan, on going monitoring of the actions was not in place.
- There were notice boards for women in each of the areas in maternity. Information displayed was not always up to date or completed and did not provide women or their partners with information that was relevant to their visit. For example despite it including the details from previous comments/complaints and what action the trust had undertaken. People had expressed dissatisfaction with the length of waiting time at the clinic, the trust had recorded action taken would be to update patient information informing patients of waiting times, however this was not the case.
- The representative from the MSLC told us that they were reassured by communication from the CCG that the trust were, 'not at fault' for the previous maternal deaths. We were told that the MSLC has a positive role in supporting the trust to improve its maternity service. The committee had recently January 2015 set up a new initiative to speak to women about the care they received. We were told to date there had been no formal feedback from these 'walk rounds'.
- Staff had the opportunity to provide feedback daily at handover meetings as well as at weekly meetings between sister and ward staff. However, we observed one handover which did not prompt any communication between midwives and shift leaders / managers.
- Although weekly meetings took place, the midwives we spoke with told us that they may not be on shift and that if they were they may not have time to attend and therefore they did not attend the weekly meetings and could not share with us what had been discussed.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure all incident investigations are completed in a timely manner, taking into account wider factors and embedded into practice, sharing learning trust wide as appropriate.
- Review the standards of cleaning and the maintenance of the environment and equipment taking action to ensure they are fit for purpose.
- Ensure all staff adhere to the trust's guidance on the use of MEOWS including routinely determine frequency of observations of women.
- Review the outcomes for mothers and take appropriate action to address adverse outcomes.
- Improve the quality and accuracy of performance data and increase its use in identifying poor performance and areas for improvement.
- Ensure the risk register includes all key risks and mitigating actions to reduce these risks.
- Identify common actions or issues in action plans to facilitate a more co-ordinated approach to learning and improvement.

Action the hospital SHOULD take to improve

- Display information to demonstrate the service's performance against safety measures or targets in all clinical areas.
- Ensure the signage to maternity services is clear to avoid ambulance crews and mothers and their partners experiencing delays in accessing services.
- Action should be taken to ensure all medicines are stored securely to avoid unauthorised access.
- Improve the standard of record keeping, consistently recording mothers and babies observations, MEWOS and fluid balance.
- Review the security arrangements in the service to prevent unauthorised access to wards and the removal of babies from the delivery suite or postnatal ward.
- Review the training provided to MCAs to ensure they have the necessary skills and competencies to deliver safe care to mothers and babies.
- Use a neonatal early warning score to record baby's observations including taking their temperatures within one hour of birth.
- Ensure all policies reflect current national guidance and these are communicated to all staff. Including drafting and implementing a maternal collapse policy in line with professional guidance.
- Ensure all staff are familiar with the structured communication tool method Situation, Background, Assessment, Recommendation (SBAR) and are able to use this tool effectively.
- Review staffing and skill mix, including the percentage of non-permanent staff used to ensure they are appropriate to meet the needs of mothers and their babies.
- Ensure all midwives understand the MCA, how this relates to their practice.
- Explore ways to improve the response rate to the FFT and alternative ways to collect feedback from mothers and their partners.
- Improve the provision of translation services and availability of written information in a range of languages other than English.
- Improve the response times to complaints.
- Explore ways to increase the level of challenge among staff in relation to poor standards and performance.
- Develop the leadership skills of shift leaders to prepare them for this role and hold them accountable for their performance.

This section is primarily information for the provider

Enforcement actions

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We served a Warning Notice.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We served a Warning Notice.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We served a Warning Notice.