The Hillingdon Hospitals NHS Foundation Trust

The Hillingdon Hospital

Inspection report

Pield Heath Road
Uxbridge
UB8 3NN
Tel: 01895238282
www.thh.nhs.uk

Date of inspection visit: 08 August 2023
Date of publication: 14/02/2024

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at The Hillingdon Hospital

Inadequate 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at The Hillingdon Hospital.

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

The Hillingdon Hospital provides maternity services to the population of Hillingdon, Uxbridge, and surrounding areas.

Maternity services include an early pregnancy unit, maternal and fetal medicine, antenatal clinic, maternity day assessment unit, outpatient department, maternity assessment unit, antenatal ward (Katherine Ward), labour ward, midwifery led birthing centre (closed during our inspection), 2 maternity theatres, 2 postnatal wards (Alexandra Ward and Marina Ward), and an ultrasound department. Between April 2021 and March 2022 4,085 babies were born at The Hillingdon Hospital.

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

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

Our rating for this hospital stayed the same. We rated it as inadequate.

Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well-led as Requires Improvement.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the maternity labour ward, triage service, the bereavement suite, theatres, and the antenatal and postnatal wards. We visited the 4-bedded midwifery led unit (MLU), but this was closed for births during the inspection.

We spoke with 12 midwives, 2 maternity support workers, 2 housekeepers, 4 women and birthing people and 2 birthing partners. We received 6 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 8 patient care records including observation and escalation charts and 8 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

Our findings

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

Maternity

Requires Improvement 

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff had training updates in key skills, including adult basic life support, safeguarding and Practical Obstetric Multi-Professional Training (PROMPT). Not all medical staff had an annual appraisal. Not all staff had training on how to recognise and report abuse or how to apply it.
- Emergency equipment was not always maintained or checked appropriately and not all wards performed well on audit for cleanliness. Staff did not always complete checklists to show cleaning had taken place.
- At the time of the inspection not all ward exits were secure. The design of facilities and premises did not always keep people safe. The environment was aged, and one of the two passenger lifts was not always working. Security of the service was not always sufficient. Staff did not always document if water outlets were flushed in line with national guidance.
- Staff did not always record waiting times within triage and not all women and birthing people were assessed by an appropriate clinician within safe time frames. Staff did not always complete all triage documentation. Staff did not always fully complete risk assessments for women and birthing people on arrival, using an assessment tool. There were delays for induction of labour.
- Staff compliance rates for CTG monitoring did not always meet trust targets. During times of high activity and acuity, staff reported difficulties in finding colleagues to review cardiotocographs (CTG). Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.
- Not all babies were born in the delivery suite. Due to delays, some were born in the antenatal ward, in triage or before arrival at hospital. This was a risk to women, birthing people and babies.
- The service had issues with retention, and sickness of staff. Midwife staff numbers were sometimes low. Leaders did not always have the resources to adjust staffing levels daily, according to the needs of women and birthing people and staffing regularly did not match the planned numbers.
- Medicines were not always stored at the correct temperatures and pharmacist checks were not always carried out. Emergency medicines were not always stored correctly, and not all staff on wards or triage were aware of where these were stored.
- Senior midwives were not always visible and approachable in the service for women and birthing people and staff, providing limited support after hours.
- Leaders did not always ensure effective governance processes to ensure sufficient and timely learning, or actions to be taken, to prevent recurrence of incidents. Staff did not always carry out duty of candour in a timely way.
- Leaders did not always ensure policies and processes were reviewed to reflect up to date national guidance. There was a lack of action planning from the findings of clinical audit.
- Not all staff felt respected, supported, and valued. The service did not always promote equality and diversity in daily work. Not all staff felt confident raising concerns.
- People whose first language was not English did not always have access to interpreters throughout their care.

However,

- We observed caring attitudes and behaviours of staff throughout our inspection.

Maternity

- Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff used equipment and control measures to prevent and manage infection, and managed clinical waste well.
- There was a clear recruitment and retention plan. Managers made efforts to mitigate risks when shifts were unfilled where possible, reassigning staff to areas of highest acuity. The service had enough medical staff with the right qualifications, skills and experience. The service provided information to all staff about training and career opportunities.
- Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and available to all staff providing care. Staff recognised and reported incidents and near misses. The service used systems and processes to safely prescribe, administer, record medicines.
- Maternity service leaders had the skills and abilities to run the service. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Ward staff understood practical plans to improve maternity for local women, birthing people and communities.
- Staff worked hard and were focused on the needs of women and birthing people receiving care. The service promoted a culture where women and birthing people and their families could raise concerns without fear.
- Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations. Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed most courses. Not all medical staff completed basic life support or obstetric emergency skills training.

Nursing and midwifery staff received and kept up to date with their mandatory training. Ninety-six per cent of staff had completed 16 mandatory training courses against a trust target of 90%. Eighty-three percent of registered midwives had completed adult basic life support training, although a further 6 staff had places booked on the next available course in August 2023.

Not all medical staff received and kept up to date with their mandatory training. Although 90% had completed mandatory training courses, compliance rates ranged between 62% for moving and handling training and 99% for equality and diversity training.

The service made sure that staff received multi-professional simulated obstetric emergency training. The service provided staff with mandatory Practical Obstetric Multi-Professional Training (PROMPT). Managers reviewed training compliance regularly. The compliance rate for midwives and maternity support workers met the trust target of 85%. Not

all medical staff attended planned PROMPT sessions. Compliance data showed 75% of obstetric consultants, 79% of obstetric junior staff, 89% of consultant anaesthetists and only 38% of anaesthetic junior doctors had completed the training. Therefore, not all medical staff attending deliveries had completed up to date multidisciplinary training to respond to emergency obstetric situations which was a risk.

Following the inspection, the trust provided updated PROMPT compliance data for the end of October 2023. Updated data for medical staff showed varied changes and still fell short of the target. Compliance for consultants was 75% of 16 staff, junior doctors 52% of a total 29 staff, anaesthetic consultants 50% of 12 staff, and anaesthetic junior doctors 42% of 12 staff. The trust provided information regarding staff booked to complete training, and by December 2023 the trajectory rates were consultants 100%, junior doctors 76%, anaesthetic consultants 92%, and anaesthetic junior doctors 50%. This meant the risk remained regarding junior medical staff.

The service did not meet the trust target for adult basic life support training for medical staff. The compliance rate was 71%. Although the service met the overall compliance rate for neonatal life support, only 75% of obstetric consultants, 79% of obstetric junior doctors, and 85% of neonatal consultants had completed the training. Therefore, we were not assured there were enough suitably trained medical staff to respond to emergency life-saving situations involving newborns.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. The risk and governance team reviewed the content of training courses and linked this to any recent themes from incidents. Training included cardiotocograph (CTG), (a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour) training which included a competency test. Topics also included fetal physiology, types of hypoxias, (oxygen deprivation) in unborn babies, fetal heart rate changes, risk factors, and fetal growth restriction. Staff took part in obstetric emergency ‘skills and drills’, including adult and neonatal life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. Midwives told us managers provided protected time for training and they were able to complete this in work time. Leaders discussed training compliance at governance meeting and escalated concerns to the board.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse or how to apply it. Not all ward exits were secure.

The service provided staff with training specific for their role on how to recognise and report abuse. We looked at the contents of the safeguarding training staff completed; it covered the expected modules for safeguarding level 3 training. Leaders added an additional 5 hours of training to the safeguarding training curriculum to include perinatal mental health, clinical psychology, learning disability and the Mental Capacity Act including deprivation of liberty safeguards.

Not all medical staff had completed level 3 safeguarding children training; the level required for their role and as set out in the trust's policy and national intercollegiate guidelines. The trust target for safeguarding training was 90%. The trust provided updated information on safeguarding training following the inspection. Although additional training had been provided, the compliance rate for level 3 safeguarding for medical staff was below target at 63%. The compliance rate for midwives and support staff met the trust target with a compliance rate of 91%.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. When staff identified safeguarding concerns women and birthing people had birth plans with input from the safeguarding team.

The service monitored cases where staff had identified female genital mutilation (FGM) and reported these monthly to national statistics data collection. The service had audited this aspect of care and identified poor staff compliance to capturing this information. Trust records showed a repeat audit was planned, but a start date was not provided. The trust FGM screening process showed numbers of FGM cases had increased significantly in recent times and the department had identified a need for a FGM lead. The maternity service had identified the need for a part time midwife and stated they were working towards recruitment.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who were available 24 hours every day and staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

The named safeguarding midwife held maternity safety meetings every 2 weeks to discuss ongoing risks and to discuss any pre-birth safeguarding plans for unborn vulnerable babies. The named safeguarding midwife also produced a maternity safeguarding newsletter every quarter and would email any information for immediate learning.

Staff followed safe procedures for children visiting the ward. Staff followed the infant abduction policy and completed infant abduction drills. We saw posters in the department and staff explained the infant abduction policy. Staff had practised what would happen if a baby was abducted within the 12 months before inspection. This simulated abduction highlighted improvements were needed and the maternity leadership team's action log showed capital planning and prioritisation for additional cameras had been added to the agenda for the next governance meeting agenda. Staff provided visitors with wrist bands to show staff they were authorised.

We found that not all ward exits were secure. Although staff told us doors were monitored and access was controlled with staff swipe cards or by a member of the team at the nurses' station, some exits were push-button controlled only. This meant anybody could leave the ward, including labour ward, without a swipe card. Staff told us risks were reduced because the nurses' station would always have staff present and doors were always observed by cameras. However, we found one exit was not monitored to prevent baby abduction. We escalated this as a concern to the leadership team at the end of our inspection. Following our inspection, the service provided risk assessment showing the security of exits was a low risk with a score of 3 and a quote obtained for installation of an intercom system. The service sent further information in January 2024 that stated, "The Trust has since made a decision to secure swipe card reader only access to replace exit buttons in all maternity inpatient areas. This work is due to be completed by 19 January 2024".

Cleanliness, infection control and hygiene

Maternity

The service met most trust standards for cleanliness, but staff did not always complete checklists to show cleaning had taken place. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection.

The service met most trust standards for cleanliness. The service told us they had achieved trust compliance for different cleaning audits. The latest trust audit showed compliance across the department was below the target at 82% for cleaning of mobile equipment and labelled with I Am Clean stickers, and areas hard to reach being free from dust.

Trust cleaning audits showed for the month of June 2023 Katherine Ward had missed the cleanliness targets of 95%. Domestic cleaning compliance was 95%, but nursing cleaning compliance was below the target at 91%. The cleaning audit scores for Alexandra Ward were 94% for domestic cleaning and 100% for nursing compliance against the trust target of 95%.

Records showed there were gaps in cleaning checklists between 25 June and 12 July 2023 on Alexandra Ward, and there were further gaps within the checklists, between 10 June and 24 June 2023, and on 3 shifts no cleaning was documented at all. However, on Marina Ward all cleaning checklists were complete.

The trust target for cleanliness for the labour ward was 98% and the April and June cleaning audits did not quite meet the trust target for nursing cleaning at 96%. Following feedback, leaders took immediate action to ensure improvements in ward cleanliness and completion of checklists.

At the time of our inspection, maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. We observed staff cleaned equipment after use, including couches in the antenatal clinic and used I Am Clean Stickers to show equipment was clean and ready for use.

We observed staff followed infection control principles during the inspection. Leaders completed regular infection prevention and control and hand hygiene audits and data showed staff completed hand hygiene audits every month in all maternity areas. In the last year compliance was rated above 95% and the infection prevention and control audit dated from 1 May to 31 July 2023 showed PPE was available and worn in line with their PPE policy, and data showed 100% compliance.

Action plans from infection prevention and control audits showed action was taken in a timely manner where issues were identified.

Environment and equipment

The design of facilities and premises did not always keep people safe. Equipment was not always maintained or checked appropriately. Staff managed clinical waste well.

The department was designed with wards situated over 4 floors. Wards had not been refurbished to the latest national standards, but the trust had plans in place to improve the layout of the maternity department.

On the day of the inspection one of two passenger lifts was not working. Staff explained they could use a separate service lift in an emergency, but this was not big enough to take a hospital bed or patient trolley. We observed staff brought a neonatal incubator unit to labour ward to mitigate some of the risk if a baby required urgent neonatal care. Staff explained the lifts were “often out of service” and, although one lift was available, it could sometimes take a long time for staff to reach wards in an emergency. Managers told us the estate was old and there was a service contract for

the lifts. The lift was out of use for the whole day of the inspection. The maternity department risk register highlighted lifts could not be used in the event of a fire and referred to an evacuation plan that was under review. We found no incidents reported regarding lifts being out of use, and there were no risks recorded on the maternity risk register regarding the regular unavailability of lifts, the additional time it was taking key staff to attend in emergencies, or any risk assessment regarding use of the service lift. Following the inspection, the service provided an updated trust risk register showing the risk had been identified in May 2023 and updated in November 2023 following further incidents of breakdowns. One incident in October 2023 involved a member of the public was stuck in the lift that was working. The controls noted to help reduce the risk included placement of the Neonatal transfer unit onto Labour Ward, and asking staff not to use the patient lift, to reduce wear and tear on the working lift.

The midwifery led unit did not offer a home from home environment and birthing rooms were similar to those in the delivery suite. The service had removed the birthing pool to make space for a bereavement suite. Staff said the service provided information for women and birthing people to explain why this action was taken. We found a lack of information regarding this on the trust website and women, birthing people, and staff we spoke to told us they were disappointed a pool was no longer available. One birthing person told us they had considered very seriously which hospital they wanted to book with, and this had been a negative point for them but proximity to where they lived had been the deciding factor. Following the inspection, leaders told us Estates staff had assessed the rooms and birthing pools could be accommodated on the second floor in the Midwifery Led Unit (MLU), and on labour ward. These were detailed in a birthing pool business case and birthing pool group minutes.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. The birth partners of women and birthing people were supported to attend the birth and provide support.

Staff did not always carry out daily safety checks of specialist equipment. Records showed resuscitation equipment on wards should be checked daily. The most recent resuscitaire checklist audit showed staff checked 98% of resuscitaires at every shift. However, equipment checklists for July and August were blank for 2 days on Alexandra Ward and 3 days on Katherine Ward. We found no evidence of equipment checklist audits. Equipment checks were included in daily handover checklists, but checks were not completed for 10 days between 25 June and 12 July 2023.

Although there was no birthing pool, any ‘seldom-used’ water outlets should be regularly flushed to reduce the incidence of water-borne infections. Staff did not always document when these water outlets had been flushed. Following our inspection, the trust provided information to show compliance had been met in August 2023 on Alexandra, Katherine and Marina Wards, but the report was blank for Labour Ward.

Leaders had installed a new bereavement suite 12 months before the inspection and its layout and facilities reflected national guidance. The suite included separate sleeping and living areas including a kitchen for families to use. There was also a separate and secure entrance door provided. Staff controlled access so families did not have to pass through any part of the department during their stay to ensure privacy and dignity. The service provided cold cots to enable families to keep their baby with them should they want this. A bereavement midwife had been appointed full time since 2023. They facilitated mandatory training sessions once a month.

The service had enough suitable equipment in most areas to help them to safely care for women and birthing people and babies. For example, there were sufficient portable ultrasound scanners, cardiotocograph machines and observation monitoring equipment. The trust had a system to monitor equipment safety checks which were completed annually.

Each floor had an emergency resuscitation trolley but there was no trolley kept in the antenatal clinic. The closest available trolley was located down a corridor, on labour ward. This was a risk because clinic staff did not have immediate access to emergency lifesaving equipment. It also meant that if the trolley was to be used in the clinic, it would not be immediately accessible if it was needed on labour ward. Staff could not provide any documentation to show emergency access to the trolley had been assessed and any risks mitigated. We informed managers during the inspection of our concern. Following the inspection, the trust informed us the antenatal clinic had now been equipped with a grab bag and a defibrillator.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always record waiting times within triage and did not always complete all triage documentation. Not all women and birthing people were assessed by an appropriate clinician within safe time frames. Staff compliance rates for cardiotocography monitoring did not always meet trust targets. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration. There were delays for induction of labour.

Staff did not always complete risk assessments for women and birthing people on arrival in triage. The trust had implemented an assessment and prioritisation model to ensure risks were identified or acted upon, but staff did not always complete all triage documentation.

The most recent maternity triage review audit carried out in June 2023 stated, “the Triage Attendance Book column which should be completed to indicate the ‘traffic light’ red, amber and green (RAG) rated prioritisation score was not always completed. The ‘traffic light’ RAG rating should also be indicated on the top of the Care Bundle sheet. Despite the ‘how to guides’ for using the care bundles being circulated in clinical areas, emails and monthly messages, the traffic light system documentation, is still not routine practice”. The audit was due to be repeated for the same period in June 2024. The triage audit objectives included the measurement of MEOWS used, but this was not documented in the audit results. Leaders monitored the correct use of care bundles and data showed all records used the appropriate care bundle.

Although triage staff recorded arrival times in a desk-based diary, they did not always ensure high risk birthing people were seen within 30 minutes. The triage audit assessed waiting times for January to March 2023 for 35 cases. The audit did not include average waiting times, although results showed most women or birthing people included in the audit spent three hours or less in triage, in line with trust policy. The audit showed 11 birthing people (38.5%) waited over 3 hours and the longest time spent in triage was 7 hours. Notes within the audit results stated longer delays were due to bed availability for women or birthing people to be transferred to the antenatal ward. Midwives told us only junior doctors were allocated to the triage area. Midwives had reported the cause of delays was often due to waiting for an obstetric review and, because of a previous audit, a section had been added to the bottom of the care bundles for midwives to complete; “time doctor called” and “time arrived to review”. The June 2023 audit results showed staff had not always completed this section, but the audit did show 24 of 35 cases audited required obstetric review. Of these, 7 had their cases discussed with, or were reviewed by, an obstetric registrar. The remaining 17 cases were reviewed by a junior doctor with no documented evidence of input by a registrar. Following the inspection, staff had produced a “Maternity Triage and Telephone Triage” guideline and had introduced visual cues and reminders for staff to complete risk assessments for people on arrival to triage. These included a maternity triage admission board and laminated care bundle flow charts.

Maternity

Staff completed risk assessments at each antenatal contact and had a risk level recorded. Staff could review care records from antenatal services for any individual risks. We reviewed 8 records and found risk assessments were completed regularly at every point of care and treatment provided by hospital staff.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used a maternity early warning score (MEWS) process and documentation in detecting the seriously ill and deteriorating birthing person. The MEWS chart reflected guidance and included information on early recognition of deterioration, advice on the level of monitoring required, facilitated better communication within the multidisciplinary team, and ensured prompt management of any women or birthing people whose condition was deteriorating. We reviewed 3 MEWS paper records and found staff had completed them correctly and had escalated risks and concerns to senior staff.

Managers had completed a quarterly audit of 40 records to check staff accurately completed MEWS charts and escalated risks appropriately. The most recent audit for January to April 2023, showed 70% staff compliance for full completion of charts and 85% for appropriate escalation. The audit showed the MEWS charts were not completed on every occasion, but observations were taken and documented elsewhere in the health record. The audit identified only partial compliance for records in triage. Auditors classified this as a low risk. Leaders had identified actions to improve compliance and planned to carry out another audit in November 2023.

Staff used growth charts to monitor fetal growth and they could escalate concerns or request a scan if they noted a discrepancy. Staff told us the scanning service could provide an urgent scan within 20 minutes, if necessary, if the woman or birthing person was on site at the hospital. In addition, a portable scanner was also available on labour ward for any urgent situations such as checking the presentation of a baby or reviewing the fetal heart. Midwives said they would go with a woman for a consultant review if a serious anomaly was suspected. Glucose tolerance tests (GTT) to identify diabetes, were undertaken from 26 weeks of gestation. There was a specialist community team that staff could refer to for diabetes management and support and the trust provided an app for people to access for health promotion information and advice.

Staff had reported delays in induction of labour on 56 occasions between August 2022 and May 2023. These incidents reported between 1 and 6 delays of induction of labour and included 13 incidents which were assessed as high risk for induction of labour.

Staff told us there were delays in induction of labour (IOL) whilst waiting for beds on labour ward. They said there were “too many deliveries in triage and the antenatal ward” and believed this had not been audited. We found there were 28 incidents reported between August 2022 and May 2023 for deliveries in areas other than labour ward. Staff kept a delivery box on the antenatal ward to mitigate this risk. Following the inspection, we asked the service to provide data on the number of births which had taken place in areas other than delivery suite. Figures provided showed from 1 May to 30 November 2023 there had been 19 births on the antenatal ward and 8 births in triage. A further 9 babies had been “born before arrival” on the unit. The service told us “The trust is aware of the incidents and the maternity unit are currently undertaking a review of all births that have happened outside the labour ward, this will be completed by the end of January 2024”.

Staff also recognised a regular shortage of beds available on the antenatal ward. We observed medical and midwife handovers where staff discussed all birthing people including those due to come in for assessment. Staff discussed birthing people experiencing prolonged delays in labour following spontaneous rupture of membranes (SROM), a

possible infection risk. It was a recognised action for those with SROM of over 24 hours for staff to undertake CTG monitoring, ideally on the antenatal ward, but this could also be done in triage if there was no space for a formal admission. Cardiotocography would also be organised to take place in triage or day assessment unit for any booked inductions of labour where no inpatient bed was available.

A centralised cardiotocography (CTG) monitoring system for labour ward and triage had been available since February 2023. Cardiotocography is used during pregnancy to monitor fetal heart rate and uterine contractions. Staff accessed the system by using any computer within labour ward. There was a large interactive screen available for use by any authorised staff, located in the clinical handover room. Staff reported it had improved oversight of CTG activity. We observed staff using it during handover when discussing women and birthing people in labour and planning their care.

Staff used national recommendations for a 'fresh eyes approach' to safely and effectively monitor fetal wellbeing. Leaders monitored staff compliance to monitoring fetal wellbeing during labour when using continuous CTG. Records showed staff recorded hourly fresh eyes in 70% of cases. Also, 78% staff compliance for completion of CTG documentation, and this had been assessed as "acceptable performance to comparator set". The targets were set at 100% for patient identification details and recording of the maternal pulse.

Other CTG standards had a target of 95%. Results showed staff compliance to recording uterine activity was 50% and 70% for recording maternal pulse. The audit did not measure documentation of management plans following CTG. Leaders identified risks relating to poor compliance. For example, staff compliance to RAG rating risk assessments was poor, although actions had been identified with timelines set and responsible leads agreed. A reaudit was planned for September 2023. Following the inspection, the trust provided additional data from an audit of records from June 2023. Themes from that audit were of "overall poor documentation, few (fresh eyes) stickers completed in full". The Royal College of Midwives describes "fresh eyes" to mean a midwife or obstetrician regularly reviews the fetal heart rate trace with a colleague to reinforce good practice and help with decision making. The trust policy required midwives to use fresh eyes stickers every hour during CTG monitoring. The June 2023 audit also reported "use, or documentation, of alternative means of auscultation (listening to the unborn baby's heartbeat) prior to CTG being commenced is very poor" at 20% of records audited. The trust provided a further update in January 2024 stating an improvement plan to address the poor compliance was in place and would be monitored by the service.

Updated results showed compliance to recording uterine activity had increased to 60%, 88% for recording maternal pulse, and 88% for use of a buddy system to provide an objective holistic review of care. Also in January 2024, the trust provided a further update on CTG training compliance. This showed compliance figures for December 2023 and all staff groups had met the trust target of 90% for CTG training.

Staff told us, and audit showed, labour ward staff experienced key challenges during high activity and acuity, and staff reported difficulties trying to find colleagues for fresh eyes reviews of CTGs.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. There are 5 steps in the surgical safety checklist; team safety briefing, sign in, time out, sign out and debriefing. We observed 1 case in theatre during the inspection, staff completed the checklist correctly. However, we observed the sign in was not completed as a clear, separate procedure by the team, as stated in national guidance.

Managers completed an audit of staff compliance for using the WHO checklists from June to August 2023. Results showed staff did not record the 'sign in' for 4 cases over the 3-month period and compliance for 'sign in', 'time out', and 'sign out' varied between 70% and 90% compared to a target of 95%. The overall compliance rate for completion of the

Maternity

WHO maternity checklist was 87% of cases in June, 95% in July, and 89% in August 2023. In August, compliance for "checks of the woman's name" at time out (before the start of the skin incision) had dropped to 50%. The audit also identified "the 'sign out' section was left blank and not fully completed on some occasions. This is a key section in checking that swabs, needles and instrument counts are correct as well as Positive Patient Identification (PPID) for the labelling of newborns".

The WHO check list completion was a key factor in the never event that occurred in April 2023 and demonstrated a lack of learning. The sign out section was still being found to be blank when "increased vigilance" had been a recommendation following the never event. Audit recommendations to the service maternity governance group noted "weekly audits of WHO Checklists need to take place until it is fully embedded". This was not recognised by the service as a risk, and in January 2024 the trust provided further information stating they had not identified any need to add this on the risk register as it was "appropriately managed by other governance routes such as monthly audits which was showing an improvement". Following our inspection, the trust provided updated audit data for completed WHO checklists including September and October 2023 data. Audit results showed an improving trend and in October all records audited showed 100% compliance for all sections. The team planned to continue the audit monthly to ensure the entire process was fully embedded.

The trust described, and we observed, how staff responded to unexpected medical conditions and emergencies on the maternity unit. We heard examples of good multidisciplinary working with other specialities and in emergency situations.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff contacted the perinatal mental health team during normal working hours and the psychiatric liaison team out of hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Staff accessed information on patient mental health, medical and social history. These were completed by women and birthing people on referral and booking. The community midwife Topaz team looked after vulnerable people and could review this information to assess risk and take action when required.

The service had completed ligature point risk assessments for each area within the maternity service and identified areas of risk. Risk scores were recorded, and control measures identified. Staff knew about ligature risks in their areas and how to mitigate them.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff completed a specific form designed to escalate concerns which included situation, background, actions and recommendations (SBAR) when escalating clinical concerns. This was peeled and stuck in the patient paper record to document the information given.

Staff monitored those who did not attend (DNA) appointments and followed up women who DNA twice and would refer to the Topaz team for a home visit if there were concerns. They referred to health visitors for safeguarding, perinatal health, female genital mutilation (FGM), or smoking cessation referrals, and to GPs or social care teams for other concerns.

The Topaz team carried out a daily walkaround of the wards to provide advice and support to staff and vulnerable families. There was also an on-call Topaz midwife for support out of hours.

There were specialist clinics provided for endocrine conditions. Staff reported there was a higher incidence of risks in the local populations. There was also anaesthetic assessment, gestational diabetes clinics, and specialist midwife-run clinics for patients with a raised BMI.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff used a Baby Early Warning Trigger and Track (BEWTT) tool to allow early recognition of physical deterioration of babies or risk of neonatal illness. Managers reviewed 40 sets of records from January to April 2023 and results showed staff escalated risk correctly most of the time, although 2 cases showed risk factors had not been identified and BEWTT charts were not used.

Newborn screening including blood spot, hearing screen and newborn and infant physical examination (NIPE) checks were completed and shared with community staff. There were midwives trained to carry out NIPE checks who performed approximately 40% of NIPE examinations. The remainder were performed by doctors prior to discharge.

The service provided transitional care for babies who required additional care. The transitional care unit was located on Alexandra Ward. We saw posters and information on infant feeding and staff provided breastfeeding support. There was a secure fridge for storage of expressed breast milk for transitional care babies.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. There were clear guidelines for transfer of women, birthing people, and babies to other hospitals in the region.

The service monitored the numbers of women and birthing people readmitted to hospital and avoidable term admissions of neonates on their dashboard.

Midwifery Staffing

The service had issues with recruitment, retention, and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. There was a clear recruitment and retention plan. Managers made efforts to mitigate risks when shifts were unfilled where possible, reassigning staff to areas of highest acuity.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings’. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Between January and March 2023 there were 88 red flag incidents where there were insufficient staff to cover all roles and shifts. Staff also used the incident reporting system to raise “red flags” for delays or missed care and escalated delays through the governance processes to maternity leads.

Maternity

Actual staffing rates for day shifts ranged between 78% and 83% and night shifts were between 87% and 90%. This did not appear to reflect the serious understaffing felt in the service and the trust's live acuity tool showed a RAG rated status for acuity during this time period. Acuity was met for only 63% of shifts, the department was up to 2 midwives short for 29% of shifts and 2 or more midwives short for 8% of shifts. Ward staffing rotas showed several shifts per week were unstaffed, even with use of bank staff and a high reliance on agency staff.

There was a supernumerary shift co-ordinator on duty around the clock on labour ward who had oversight of the staffing, acuity, and capacity. However, managers did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice, although midwives told us they were not expected to work in areas unfamiliar to them.

The staff rosters for July and August 2023 showed the postnatal ward was regularly understaffed by at least 1 registered midwife every day, except for 4 days across the whole month of July and for 6 days in the first 4 weeks of August. Staff said that on the days when there were sufficient staff rostered, they would be relocated to labour ward or triage. Managers maintained oversight of staffing for the week ahead and there was a bleep holder who visited each ward 4 times a day to review the staffing status and deal with any immediate staffing problems.

On the day of the inspection there were sufficient midwifery staff allocated to triage, but staff told us there were not always enough staff to care for all women and birthing people. Staff said there should always be 2 midwives but there was often only 1 midwife and a midwifery support worker.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. The trust had completed a maternity safe staffing workforce review in line with national guidance in February 2022. At the time the trust had calculated the overall clinical establishment against a total of 4125 births per year. A case mix study showed that the service required a further 16 whole time equivalent (WTE) non-clinical specialist midwives. There was an ongoing, comprehensive recruitment drive to appoint more midwives including some students ready to complete their studies and start in post and midwife vacancies were advertised.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank and agency nurses. The number of midwives and support staff did not always match the planned numbers. Vacancy rates had increased from 15% (24 WTE) in January to 22% (32 WTE) in March 2023. To address this, the trust ran a rolling recruitment programme and had recruited 5 international midwives. The trust midwifery and maternity staffing report for January to March 2023 stated, "Midwifery staffing remains a significant risk at Hillingdon and is registered on the divisional risk register for Planned Care". At the time of the inspection there were 30 registered midwife vacancies and 7 midwifery support worker (MSW) vacancies.

These factors affected the quality of care provided and there had been several closures of the midwifery led unit (MLU) including on the day of our inspection, and the ability to provide a home birth service was also affected on several occasions.

Managers carried out wellness interviews to support staff to stay well at work. The human resources department carried out "stay interviews" but staff said they felt these did not impact on retention rates. The trust had organised wellbeing check-ins, offered occupational health and employee support, and a "Wellbeing at Work Webinar for Nurses and Midwives" in February 2023. Staff told us there had been variable consensus for the effectiveness of the wellbeing sessions.

Staff told us sickness rates had increased as staff became more stressed, particularly amongst more recently qualified staff. The staffing report for January to March 2023 showed the department sickness rate was static at 6% and stated "Sickness has a significant impact on staffing due to the continued midwifery vacancy factor. Shift cover is supported using bank and agency staff. On average the 6% each month reported sickness was divided into 2.8% long and 3.2% short-term absence".

Theatres were staffed with scrub nurses and operational department practitioners and registered nurses cared for women and birthing people in recovery.

Managers requested bank and agency staff familiar with the service, used regular agency staff, and made sure all bank and agency staff had a full induction and understood the service.

The service made sure staff were competent for their roles. Midwives completed practice development reviews.

Managers supported staff to develop and there were specialist roles in place. A practice development team including a clinical practice facilitator and 4 practice development midwives supported midwives and support staff and a clinical education lead supported doctors. The team organised regular multidisciplinary training days. The trust also provided eLearning courses, a simulated skills teaching environment, and online Teams calls for standards for student supervision and assessment. The trust provided newly qualified midwives with a year's preceptorship package to ensure competence and confidence in their role.

Midwives completed an annual electronic practice development review (ePDR), for which the compliance rate was 94% for midwives. The practice development team maintained a list of part time professional midwifery advocates (PMA) to support staff. There was an active training programme for new PMAs. However, ward staff told us they felt the system was not embedded and there were not sufficient PMAs to support midwives.

Managers made sure staff received any specialist training for their role. Midwives undertook lead roles, for example in safeguarding, infant feeding, and wound care. Midwives were offered specialist training including a leadership development framework in partnership with other local trusts, practice development skills and the professional midwifery advocate course. The service provided a development role for deputy ward manager posts for Band 6 midwives where they could learn about leadership roles. There were 3 posts on the postnatal ward and 2 on the antenatal ward and included a competency framework for midwives to complete.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. However, junior doctors said the department always felt understaffed. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. Not all medical staff had an appraisal.

The service had enough medical staff to keep women and birthing people and babies safe. The consultant medical staff matched the planned number. There were 16.3 WTE consultants including one full time locum consultant. The rota required 16 full-time registrars and at the time of the inspection there were 1.5 WTE vacancies at registrar grade. In August 2023 there were 7 WTE deanery specialty trainees, made up of 6 less-than-full-time trainees, and 4 full-time trust registrars. At senior house officer (SHO) level, there was a 10-person rota. In August 2023 there were 6 deanery trainees, 3

doctors who were trainee GPs (GPVT), 2 of whom were less than full time, and one vacant trust grade SHO post. Unfilled or vacant junior doctor shifts were filled by bank or agency locums. In the week prior to the inspection only 1 registrar and 1 SHO shift were unfilled. Some consultants were assigned to obstetrics only, but the majority were assigned to gynaecology as well. All junior doctors worked in both obstetrics and gynaecology.

The service always had a consultant on call during evenings and weekends. The local maternity and neonatal system (LMNS) had a set 96 hours of dedicated consultant presence on labour ward. To meet this, consultants provided dedicated labour ward cover for Monday to Friday 8am to 10pm; a total of 14 hours per day. At weekends, there was a resident consultant on labour ward for 10 hours a day 31% of the time. For the other 69% of weekends there was dedicated obstetric cover, with a separate consultant to cover gynaecology. Consultants provided a ward round twice a day with the day and night team. On-call cover was organised through a duty rota that also covered gynaecology. The trust stated in the midwifery and staffing report for January to March 2023 there were no episodes where a consultant could not attend when required. Staff told us consultants always came when asked to support labour ward staff. A separate doctor was allocated to the antenatal ward and daycare area from 9am to 5pm on weekdays so they were aware of women and birthing people waiting for reviews and inductions. There was full anaesthetic cover during the day and an on-call anaesthetist overnight to cover labour ward. An additional resident anaesthetic registrar provided cover for ITU at night.

The service had low vacancy, turnover and sickness rates for medical staff; however, registrars told us the department always felt understaffed. Midwives on antenatal and postnatal wards, and triage told us there were often long waits for doctors to attend.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Postnatal ward staff told us the obstetric middle grade or specialty training doctors (registrars) would carry out medical reviews of unwell women or those who were readmitted, but consultants did not routinely attend the postnatal ward.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Medical appraisal compliance for maternity service doctors was 78% and a further 6 doctors had a booked appraisal within the next 2 months.

Consultants held 3-monthly faculty meetings with junior doctors to discuss any concerns. Registrars had their own list of patients in antenatal clinics and some doctors had reported they sometimes felt this was difficult, although it was a good opportunity for learning. Following this feedback, consultants had audited clinics and found there had been too many reviews booked. They provided some further teaching, ensured registrar clinics ran alongside consultant clinics, encouraged “ownership”, and capped clinic numbers. Following this, managers reported complaints from junior doctors had reduced for this intake.

Medical staff told us they worked as a cohesive team, and doctors, including consultants, had provided cover during the junior doctors’ strikes showing a lot of goodwill.

Records

Maternity

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

Women and birthing people's notes were comprehensive. Staff could access paper records. The trust used a combination of paper and electronic records. There were multiple systems in use for patient notes, with some areas where staff copied information from one system onto other, therefore, duplicating work. This increased the risk of missed information.

We reviewed 8 paper records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Ward clerks ensured patient locations were updated and records were accessible for all staff involved in care.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. Staff told us there had been a severe shortage of medical records storage space, but this was beginning to improve with some additional space found at Mount Vernon Hospital (another hospital within the trust). For records stored off site, senior staff said there was a good process for retrieval.

Medicines

The service used systems and processes to safely prescribe, administer, record medicines and staff completed medicines checks. However, medicines were not always stored at the correct temperatures. Emergency medicines were not always stored correctly, or immediately available to staff on wards or triage.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 8 prescription charts and found staff had completed them correctly.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Medicines records we reviewed were clear and up to date. Midwives could access the full list of midwives' exemptions and were clear about administering within their remit. There was also provision for paper prescriptions to be printed to enable timely discharges.

Medicines were not always stored at the correct temperatures. Medicines were stored in rooms where temperatures exceeded safe storage guidelines. The trust had developed a process for identifying medicines that may have been affected. Pharmacy staff placed coloured stickers on medicine packaging to identify which medicines were at risk. The trust chief pharmacist had signed a risk assessment and reduction plan in 2018 and, following the inspection, the trust provided meeting minutes to show the document had been circulated by email and approved by the trust medicines management committee.

A memorandum was shared with senior midwives and ward managers to ensure ward staff monitored and recorded ambient temperatures and reported temperatures out of range to the sister in charge and to raise an incident via the incident reporting system.

Maternity

We provided feedback to senior leaders about staff concerns and lack of clarity and they signposted the trust risk assessment. This showed the stickers had been used for 4 months, since May 2023. However, all ward staff we spoke with who administered medicines, told us they did not understand the process or the reason for the stickers, such as which medicines should be used first. Following the inspection, the trust told us they had reviewed the process for identifying when medicines should be used and shared this with all midwives. The trust also provided a revised standard operating procedure SOP) for reviewing the impact on the efficacy of medicines if stored above 25 degrees in wards". This had been approved at the Hillingdon Medicines Management Committee (HMMC).

Staff told us they continued to record all medicines room temperatures but had not raised any incidents when they found temperatures to be outside a safe range. Staff said it was accepted that, because there was no air conditioning, the medicines rooms would be very hot throughout the spring and summer, and they had a fan to use but it just moved the hot air around. Following the inspection, the trust provided evidence to show a business case had been written and agreed to install air-conditioning units in areas where medicines were stored in the maternity service. In December 2023, the trust provided evidence to show the first unit had been installed on Alexandra Ward. The installation of air conditioning units in the other areas of maternity was reported as being in progress in January 2024.

Staff managed most medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date.

Staff checked controlled drug stocks daily. There had been a new change implemented for controlled drugs (CD) procedures and there were some opened bottles of pain-relieving controlled drugs in the CD cupboard on the postnatal ward. Staff explained that when the pharmacy department issued the medicine, they put the date on the label to show when it was dispensed but there was no clear documentation to show when it was opened. Following the inspection, the trust told us in January 2024, a recent medicine related audit had identified a gap in practice, as some opened liquid CD medicines were found not to be marked with “date open”. As a mitigation, and to improve medicines safety, it was decided that in future liquid CD medicines would be sent to wards marked with “open date” marked on the bottle.

Maternity staff reviewed each women’s medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff provided a ‘desk visit’ to the maternity unit. Pharmacy staff reviewed women’s medicines when requested by maternity staff and screened the medicines section of discharge summaries. Therefore, the consistency of prescribing and advice lacked adequate pharmacy oversight. We provided feedback to senior staff about this, and they were unaware these checks were not taking place. A lack of available pharmacy staff had been flagged with trust managers.

Some emergency medicines such as antihypertensives were not available for use on antenatal and postnatal wards, and there was no sepsis kit available on antenatal and postnatal wards. We reviewed an incident where a delivery had occurred in triage. There had been a massive obstetric haemorrhage (MOH) of 2.2 litres and staff reported no emergency drugs had been available. Following the inspection, the service provided information to show all emergency medicines were stored in locked cupboards in treatment rooms. Guidance regarding emergency kits state these should be immediately available to staff and some medicines need to be stored in a fridge. Therefore, a locked cupboard would not be an appropriate place to store them, and during the inspection we found not all staff were aware of their location. Following the inspection, the service provided information to show they were following the trust policy and guidance on safety of medicines. Staff had access to emergency medicines including haemorrhage and pre-eclampsia boxes in all areas within the maternity service. The medicines were stored in locked cupboard and locked refrigerators as per the Trust policy and staff knew how to access them in case of emergency.

There was no sepsis kit available on antenatal and postnatal ward. However, following the inspection, the Trust introduced sepsis boxes which were made available on each floor of the maternity service in the emergency cupboard.

Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

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

Incidents

Staff recognised and reported incidents and near misses. Although managers investigated incidents and shared lessons learned with the whole team and the wider service, this did not always ensure sufficient learning or actions were taken to prevent recurrence of incidents. Staff did not always carry out duty of candour in a timely way.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. Managers reviewed incidents potentially related to health inequalities. Staff reported serious incidents clearly and in line with trust policy and managers investigated incidents thoroughly. We reviewed 5 serious incident investigations and found staff had involved women and birthing people and their families in the investigations.

We reviewed 10 moderate and severe harm incidents reported in the 3 months before inspection and found them to be reported correctly.

Managers followed trust policy and guidance for grading of incidents. We found a small number of incidents involving stillbirths and intrauterine deaths with other complications were graded as moderate or low harm. Trust information showed that from 32 Perinatal Mortality Review Tool (PMRT) reports generated, 5 were graded as “C”; where the team identified care issues which they considered could have made a difference to the outcome for the baby. Some serious incidents recorded were labelled as incident closed “no identified provider error”; these included intrapartum stillbirth, neonatal death, and pelvic trauma. Following the inspection, the service added information to show incidents were graded on the level of harm attributed to the trust and had been presented to the trust’s weekly serious incidents panel to decide on the level of investigation required. However, moderate harm is described in Health and Social Care Act (2014) Regulation 20 as ‘harm that requires a moderate increase in treatment, and significant but not permanent harm; “moderate increase in treatment” means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care)’. Incidents of massive obstetric haemorrhage (MOH) and 3rd and 4th degree tears were not always acknowledged as moderate harm.

The service had reported a ‘never’ event in April 2023 for a retained vaginal pack swab. Two packs had been used and removed, and an additional vaginal swab was removed at the same time, as there was miscommunication on handover between delivery suite and theatres. During the inspection, staff reported there had been increased vigilance on transferring information and communications between multidisciplinary teams. Managers shared learning with their staff about never events that happened elsewhere.

Staff understood duty of candour requirements and provided examples of when obstetricians and senior midwives had spoken with family members. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Staff told us duty of candour conversations were recorded within the

postnatal review document or an incident record and there should be a copy within patient hand-held notes. However, senior staff told us they did not store a copy of duty of candour letters within patient records. Following the inspection, the service told us copies of duty of candour letters were securely stored on the trust's electronic system, ensuring staff could easily retrieve them and make them available when needed.

Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Managers said they shared duty of candour and draft reports with families for comment in all investigations, but staff told us the process relied on the outcome of grading and PMRT reviews that often took place several months after incidents occurred. We found an example where this had happened in a PMRT report produced in July 2023. The case had occurred several months earlier, and staff told us no duty of candour letter had been sent. Therefore, it did not show duty of candour was carried out in a timely way, or for all cases.

Following the inspection, the service told us all women experiencing a stillbirth were given a duty of candour letter before leaving the unit or at the first visit by the bereavement midwife. A change to the trust-wide duty of candour policy had been agreed by the patient safety group in November 2023 stating how the process would change with presentations to staff about the changes and provision of a duty of candour letter template.

Staff received feedback after investigations of incidents, both internal and external to the service. Staff discussed serious incidents and shared learning at monthly maternity governance meetings and leaders reminded staff of actions identified. The service had a clinical risk midwife who was responsible for sharing learning from incidents with staff. There was evidence that some changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

Managers debriefed and supported staff after any serious incident. Midwives and obstetric doctors told us how the team would meet immediately, or as soon as practically possible, after an incident occurred. This helped them to discuss the event and any immediate opportunities to support staff.

Is the service well-led?

Requires Improvement ↓↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. Most leaders were visible and approachable in the service for women and birthing people and staff. However, senior midwives were not always available or approachable in the service for woman and birthing people and staff, providing limited support after hours. Executive leaders understood and managed the priorities and issues the service faced.

Maternity service managers had the skills and abilities to run the service.

Maternity

Senior leaders were visible and approachable in the service for women and birthing people and staff. Staff told us they were well supported by their line managers and ward managers. Senior midwives and managers supported staff and processes throughout the unit during the daytime hours, but staff told us there was limited support after hours. Staff told us the head of midwifery was keen to support staff and patients and took on these tasks over and above their own role, and regularly attended or managed issues during the night. Staff told us they felt this situation could not continue, and no changes had been made for senior midwives to provide more regular, planned support after hours. Following the inspection, the trust told us a review of planned support for out of hours had taken place resulting in 'Manager on call' consultation. This was launched in January 2024 with plans for implementation from February 2024.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Staff told us some of the staff shortages were caused by staff moving into senior posts.

The service was supported by maternity safety champions and non-executive directors. Staff said they visited wards on a regular basis and staff spoke of how accessible and encouraging they were.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress. Although ward staff were not aware of a vision for the service, they understood practical plans to improve maternity for local women, birthing people and communities.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Senior staff said the vision was about providing first-class care and placed the maternity service at heart of what we do by working in partnership with their service users, wider partnerships within local communities, and the local maternity and neonatal system (LMNS). However, only senior staff were aware of the vision.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity voices partnership (MVP) had been involved in an inclusivity pilot to look at access for women and birthing people in community settings who need additional support. Work had started with additional finance and management support.

Managers said they had developed the vision and strategy in consultation with staff. They had developed a 3-year delivery plan that incorporated plans for improving recruitment of "quality people, growing staff, a safety culture, and improving partnerships". Staff understood a large part of the strategy was based on building a new hospital, but staff did not know when this would be built, and managers could not say when finances would be in place to begin this. Staff could explain the forward plans for the department and what that meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and they planned to revise the vision and strategy to include these recommendations. Leaders had assessed the service's compliance with Ockenden recommendations and knew how to apply them and monitor progress.

Culture

Maternity

Not all staff felt confident raising concerns. The service did not always promote equality and diversity for staff in their daily work. However, the service was focused on the needs of women and birthing people receiving care and promoted a culture where women and birthing people and their families could raise concerns without fear.

Staff worked within and promoted a culture that placed people's care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect for women and birthing people were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Most, but not all, staff we spoke with felt respected, supported, and valued**.** Most staff were positive about the department and its local leadership, and most managers said they felt able to speak to leaders about difficult issues and when things went wrong.

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

Following concerns through the trust's freedom to speak up process at the beginning of 2023 the senior management team had organised an external independent review of culture about a range of themes including views on unfair working culture for staff from ethnic minorities and for staff with caring responsibilities outside of work, as well as a lack of diversity in management positions, and career progression. The independent review was completed in April 2023. Findings were shared with leaders in June 2023, which included the themes of unsafe staffing and associated workforce issues, management responsibilities, inappropriate professional behaviours and treatment of support staff, ineffective HR support, and lack of support from the trust. The review suggested recommendations for change and improvement including some directly related to government reports including the Ockenden review and report of a trust public inquiry, along with improvements in access to the freedom to speak up guardian. Senior leaders told us the review had been taken seriously and work regarding the recommendations was in progress. During our inspection, staff told us whilst the trust had conducted various activities and communicated information, not all staff felt all the findings had been shared openly. Some staff, including the executive team, told inspectors they were unaware of the review's outcome.

We observed supportive relationships between staff groups. Midwives told us senior staff felt more able to challenge a doctor if a clinical decision or action was needed and one midwife told us they had challenged a doctor regarding a cardiotocography reading. Doctors told us they were well supported by consultants and enjoyed their rotations. Consultants encouraged doctors to develop skills and always came to help when asked. Staff held a multidisciplinary debrief following any serious incident to check on staff welfare and to consider any immediate learning.

Students gave positive feedback about staff attitudes and opportunities available to them. Practice development midwives met students before their first shift to match them to the most appropriate teachers to suit their individual needs.

Staff were able to use a local electronic reporting system to identify others who displayed trust values and went "over and above" for their patients or colleagues. These were recognised in ward meetings, bulletins, and by managers. Managers organised staff away days for team learning and wellbeing. The trust provided altered uniforms for staff requiring more comfortable clothing, for instance those with mobility restrictions, pregnancy, or menopause.

Maternity

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. Women and birthing people, relatives, and carers we spoke with knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Senior staff contacted those who raised concerns or complaints and recorded resolutions.

The trust shared information on formal complaints received and had identified themes and trends. The trust shared the information about specific actions taken, lessons learned, and outcomes for each of the complaints logged. Although the most common themes were about clinical care and unsympathetic or aggressive staff behaviours and poor attitudes of staff, we observed caring attitudes and behaviours of staff throughout our inspection.

Complaints were shared with the board and maternity governance group minutes from April 2023 showed complaints had been reviewed. The minutes showed the department's response and included: setting up a working group looking at the induction of labour pathway with local stakeholders for the development of a translation app to help with communication in other languages; a review of cleaning standards; and incorporating patient culture as a part of mandatory training for midwives.

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

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

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority or disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

Governance

Leaders operated a governance system however this was not always effective. Processes regarding actions and learning following incidents were not always followed effectively. Processes for reviewing policies and processes did not always ensure these were reviewed in line with national guidance.

The service had a governance and reporting structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. Senior midwives told us they attended maternity governance meetings and neonatal mortality and morbidity meetings which fed into the governance system. They told us there was "a good voice" for maternity specific issues and they were taken seriously by governance leads and the board. However, following incidents, staff did not always carry out effective, quorate reviews. Not all actions were completed as recommended in incident reviews including PMRT and HSIB reports. Staff did not always have access to policies and guidance which had been reviewed in line with national evidence-based practice. Although policies were in date, some had long review dates of up to 5 years. Not all NICE guidance referenced within policies was up to date. Following the inspection, the trust told us it had been agreed at the Clinical Outcomes and Effectiveness Group in October 23, that all trust guidelines would now be reviewed at 3 years.

The reduced fetal movements guideline had been issued in November 2022 and the outpatient induction of labour guideline had 2 review extensions and was 5 years old. This meant the leaders could not be assured staff were following the correct and most up to date guidance available. Another example was the trust guidance in the pre-existing diabetes guideline which did not meet national guidance and did not reflect processes that staff followed. This was regarding commencement of Aspirin from 12 weeks' gestation to delivery. National guidance stated a dose of 150mg was required but trust policy stated 75mg. The policy stated delivery should take place at 37 weeks or 36 weeks +6 days, which was in line with national guidance. However, this did not match what staff told us, or gestation dates of birthing people with these complications at the time of the inspection. Following the inspection, the service told us about an updated guideline for outpatient induction of labour, which had been written and was published in October 2023.

Staff at all levels said they were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, managers did not report all risks and did not always take effective action to prevent some issues from recurring.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service had an audit programme in place for national and local audits and provided results of audits undertaken for documentation such as situation, background, assessment and recommendation (SBAR), baby early warning trigger and track (BEWTT), cardiotocograph (CTG) and triage. They audited performance and identified where improvements were needed, however, repeat audit arrangements were sometimes set for a year later.

Leaders presented audit outcomes to the monthly "audit morning" for review and provided oversight to the board through the maternity safety report, dated April 2023. Leaders evaluated care and identified actions when outcomes were worse than expected. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Each audit included objectives, achievements, and areas for improvement, but the majority did not contain specific measurable and timebound actions.

The maternity safety report from April 2023 included results from audits including a perinatal mortality audit. This showed the trust had a total of 7 stillbirths and one neonatal death in the period from 1 January to 31 March 2023. This meant the stillbirth rate was 6.83 per 1000 births and above a national average for England of 3.8 per 1000 births, and this had remained the same as the previous quarter. The trust maternity dashboard showed for the year 2022 to 2023 there had been 23 stillbirths. The audit also took into consideration the local maternity and neonatal system (LMNS) exploration of potential correlation between workforce shortages and poor outcomes. The audit included looking into the high ratio of cases of women/birthing people who were un-booked, late bookers, or asylum seekers, as well as their ethnicity and from 9 cases in total, 7 were of Asian or African ethnicity. Recommendations and learning following the

audit included improving communication between the different organisations involved in working with vulnerable people, increasing the provision of personalised care and support plans, and provision of smoke free pregnancy. Since the audit, the service had begun the recruitment process for a specialist midwife for vulnerable women and asylum seekers.

Since the inspection, the local Integrated Care Board (ICB) had noted a continuing increase in the stillbirth rate and, in December 2023 a review was instigated with internal and external reviewers.

A perinatal mortality review tool (PMRT) review identified there was a lack of local bereavement care pathway information for staff to follow. There were no actions identified in conclusion of the report to address this or prevent such an issue recurring in future. Managers planned a repeat of the maternity triage review audit for 12 months following their identification of requirements staff had not met.

Although the service told us the governance and safety framework included incidents, complaints, claims, clinical supervision and 'speaking up', all of which could give rise to issues, improvements and learning opportunities, we noticed some missed opportunities for learning and actions to avoid recurrence of incidents or similar cases. We noted reviews of 2 cases had not been completed following transfers of babies delivered at The Hillingdon Hospital and transferred to another unit. These were from incidents that occurred in November 2022 and February 2023. Following the inspection, the trust provided a completed PMRT for the case from February 2023. This had been completed in August 2023 and published in October 2023 by the trust where the baby had been transferred. The action arising from the report was for "Reminder to staff via newsletter RE: antibiotics in premature labour. Add to PMRT newsletter 01/12/2023".

Trust processes required there be an external panel member for PMRT reviews. We noted this was not the case in all the reports provided to us. Only 1 of 5 reviews showed an external member was present. Following the inspection, the trust provided a list of reviews undertaken in 2022. This listed reviews and gave the role of an external panel member for all but the last 2 reviews. Another review was carried out jointly with another trust and there were staff from both trusts involved in the review. Following PMRT reviews, staff did not always take effective action to prevent some issues from recurring. In 4 out of 5 cases of stillbirth or neonatal loss shared with inspectors the PMRT report showed "The review group identified care issues which they considered would have made no difference to the outcome" for the mother or baby. We found there were reviews with several actions that included reminders to staff in 3 cases regarding the mother or parents having poor or no English. The perinatal mortality reviews summary report for January 2022 to January 2023 showed the actions relating to issues raised which were identified as relevant to the deaths of babies were "reminders" were to be shared with staff through planned training, emails, or via the service maternity matters bulletin.

The service used a maternity dashboard to monitor risk, safety, and performance. Information was regularly updated and used in labour ward forum and governance meetings.

The service recognised there were delays in providing inductions of labour (IOL). The trust's policy was to carry out IOL at 40 weeks plus 10 -12 days. Staff said this was later than other trusts and had initially been based on NICE guidelines. The most up to date NICE guideline: Inducing Labour, introduced in November 2021, was not recognised within the policy. Following the inspection, the trust told us staff had reviewed and updated the policy with the correct guideline during the inspection and we saw evidence of this. Managers monitored waiting times for induction of labour through an induction list accessed via a shared drive. Senior doctors said they were "looking to change the induction of labour process, also to change the method of IOL to a more mechanical offering". Following the inspection, the trust told us doctors had implemented 2 mechanical methods for IOL. They said this would not change the process for IOL but would offer another option.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff identified risks through the incident management system, and reviewed and recorded them in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. The maternity risk team managed the obstetrics risk register, and the top 3 risks were information loss from the electronic patient record due to overwriting software issues, midwifery staffing, and lack of storage space for maternity health records. Leaders rated risks according to seriousness and identified controls for mitigation and actions taken.

There service had plans to cope with both known risks and unexpected events. The service had an escalation policy in place to proactively manage activity and acuity across the service and the trust which reflected the current staffing position.

Information Management

The service collected reliable data and analysed it. The information systems were secure. Staff could access the data they needed to understand performance, make decisions and improvements. However, limitations of software meant some data was difficult to access, and staff were unable to submit some data or notifications to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. However, staff reported some data was unavailable and senior leaders said they had not been able to upload specific data to the national dashboard, for example, staff were not able to record information about if women and birthing people were smoking at the time of booking. Governance team members said there was a national issue with their software provider. Some data had been unavailable since November 2022 and staff were checking back further. Senior staff told us this was the highest risk on their risk register, and they supplied the information to the national digital team. They said this risk was partly mitigated by the fact they used handheld notes in addition to the electronic system. The governance team said they were assured data was collected and performance was measured on time, but there was no evidence available to confirm this.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Women and birthing people were able to self-refer to the service and staff told us 90% completed an online form. This was available in a range of languages and the trust website could be translated into over 120 languages. The form included information on previous pregnancy and medical history, mental health, and social history. Staff used information provided to review each referral and assess risks throughout each pregnancy.

The information systems were secure**.** Staff told us they used several systems to record patient information, and these were not always integrated. For example, midwives used one system which included prompts regarding specific risks. Doctors did not always complete or update this, using paper records instead. Midwives told us escalation processes worked well and doctors reviewed and acted on risks.

Data or notifications were consistently submitted to external organisations as required. However, we noted incidents reported where massive obstetric haemorrhage of 3 litres or over, or tears graded as 3c had occurred were graded as low harm.

Engagement

Maternity

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people. However, people whose preferred language was not English did not always have access to interpreters throughout their care.

Leaders understood the needs of the local population. Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The service engaged with women and shared information using social media platforms. The service had engaged with over 400 local people via social media platforms. MVP staff sent out information and requested feedback using these platforms. They had set up groups to review patient guidelines and leaflets. They were aware of the local population and its demographics and that they were not reaching the diverse community. Staff were very aware between 52% and 58% of the local population were of south Asian ethnicity. There were several centres for refugees and asylum seekers in the local area. MVP staff told us they had begun work with the regional MVP lead on an inclusivity plan. They had held a meeting, liaising with the local children's centre lead, to identify and reach out to groups and areas they had been unable to reach in the past.

The service accessed interpreting services for women and birthing people and collected data on ethnicity. The service provided flash cards and a "padlet" to enable translation of commonly used phrases and more complex information for people whose preferred language was not English.

However, the perinatal mortality review tool (PMRT) reports we reviewed showed people whose preferred language was not English had not always had access to interpreters and improvement in access had been identified as an action for these cases since November 2022. Following the inspection, the service provided information to show they had reminded staff about using interpretation services through the PMRT newsletter, a staff email about using a translation services app, and an interpreting services presentation which was presented at a trust-wide patient engagement forum in November 2023.

Staff told us a high ratio of stillbirths occurred amongst women and birthing people whose first language was not English. They could not be sure these women understood the importance of monitoring and reporting changes in fetal movements. Staff were also concerned these people may not fully understand what they were consenting to when given verbal or written information.

It was an aim of MVP staff to be able to produce and make available all simple leaflets in the top ten languages spoken throughout the community. Information leaflets were available in different languages, accessible from the trust internet, or maternity staff could print leaflets and give them to women as required.

Trust staff accessed sign language resources to aid communication with people living with hearing difficulties. We saw posters displayed in ward areas that included QR codes or people to access information in a range of languages on topics including breastfeeding.

A poster was displayed in the labour ward staff room showing patient experience in June 2023 had been reported at 85%. We spoke with 4 women, birthing people, and their partners. Some people told us there were long delays in waiting to see a doctor and the reviews by medical staff felt rushed. One person felt that although they planned to breastfeed, they had not been given any information about breastfeeding support on labour ward. Staff told us this was available electronically and there were posters and support offered on the postnatal ward, and if people were discharged straight from labour ward, they would not know about these. People we spoke with during the inspection commended the staff for working hard under pressure and providing them with kindness and compassionate care. Some mothers we spoke with, and information we received through "CQC give feedback on care" from a small number

of people, showed they felt some staff were abrupt or rude and there was a lack of support and understanding of their individual needs. The 2022 CQC Maternity Survey results confirmed positive interactions with staff during labour and birth and postnatally. There were other reports of a lack of consistency in quality of care, varying as individual midwives changed over. There were accounts of a lack of patient-centred care and understanding, for example staff not believing patients or questioning their experiences. This impacted on the quality of clinical care, and on patients' sense of safety and support.

Learning, continuous improvement and innovation

Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us they were committed to learning and improving services. Senior leaders told us there was a variety of ways the service shared learning for example with posters, hot topics, six monthly (reported incidents) reviews, learning from complaints, the maternity serious incident meeting and an action tracker kept on the shared "risk drive". Senior staff said actions taken following 72-hour reviews of serious incidents included discussions between clinicians.

Following a national campaign regarding non-accidental injury to babies and infants, the safeguarding midwife had shared a 7-minute guidance video, circulated to all midwives, on "The myth of invisible men" involved as carers.

The trust had awarded Katherine Ward (antenatal ward) with a Trust Gold Accreditation in February 2023. Staff described the Ward and Department Accreditation as "an assurance framework that can drive towards continuous improvement focusing on patient outcomes, increased patient satisfaction and staff experience at ward and department level. It is based on an evidence-based tool with co-ordinated set of standards against which the quality and safety of patient care" and to develop continual improvement, development and learning and progression of good practice and ideas. Staff were proud they had received the first award ever given, and managers said they had maintained the high standard ever since.

Leaders had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives. There were focus groups for changes in policies and processes for the induction of labour with a new care pathway in progress with the aim of improving induction success rates.

Medical staff had developed a postnatal pelvic health service and won a regional bid for funding to provide ongoing support for those experiencing pelvic trauma during birth. The team had won a trust staff award in September 2022 for the work and presented nationally and locally to staff at other units to share good practice. They involved newly appointed part time perineal specialist midwife and postnatal physiotherapist who provided clinics for up to one year following birth and advice. The service had carried out a trial to include student physiotherapists which had provided essential skills and education for the students as well as additional support for the team. The physiotherapy service was due to begin delivering care and advice to women and birthing people on the postnatal ward. There were bladder champions on the postnatal ward (Marina Ward) and clinics had been moved to Marina Ward from gynaecology outpatients. Staff told us they had begun auditing outcomes, but no results were available at the time of the inspection. The postnatal pelvic health team had met with the MVP leads to organise feedback from local people on infographics

within leaflets provided in both antenatal and postnatal settings. They wanted to ensure information was available for people whose first language is not English, with the aim to be as inclusive as possible. The team held webinars every 8 weeks for women from Northwest London and up to 200 women could take part. Staff presented advice and information and ran question and answer sessions.

The service provided separate parentcraft classes for women experiencing language barriers, learning difficulties, and women who had given birth in another country.

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

Staff had introduced a “Hope box” for memory making with families whose baby may be taken into the social care system.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure all staff are up to date with maternity mandatory training modules, including basic life support, safeguarding training to the appropriate level, and Practical Obstetric Multi-Professional Training (PROMPT). Regulation 12 (2) (c)
- The service must ensure the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
- The service must ensure lifts are, suitable for the purpose for which they are being used, and properly maintained. Regulation 15 (c) (e)
- The service must ensure staff complete daily checks and correct provision of emergency equipment. Regulation 12 (1) (2) (a) (d) (e)
- The service must ensure it completes routine legionella water checks in accordance with national guidance to assess the risk, detect and control the spread of water-borne infection. Regulation 12 (2) (h)
- The service must ensure CTG monitoring and fresh eyes compliance rates meet trust targets and national standards. Regulation 12 (2) (a) (b)
- The service must ensure inductions of labour take place safely and in line with national guidelines. Regulation 12 (1) 2 (b)
- The service must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care. Regulation 12 (2) (a) (b)

Maternity

- The service must ensure that staff complete all documentation including waiting times and a prioritisation risk assessment for all women attending triage to identify those most at risk so that they can be assessed within safe time frames. Regulation 12 (a) (b)
- The service must ensure the proper and safe storage of emergency medicines. Regulation 12 (g)
- The service must ensure there are effective governance processes and systems to identify and manage incidents, risks, issues, and performance and to monitor progress through completion of audits, actions and improvements, and reduce the recurrence of incidents and harm. Regulation 17 (1) (2) (a) (b) (e) (f)
- The service must ensure midwifery staffing is reviewed so there are enough suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1)
- The service must ensure all medical staff have an annual appraisal. Regulation 18 (2) (a)
- The service must ensure Duty of Candour is carried out in line with regulations. (Regulation 20).

Action the trust SHOULD take to improve:

- The service should continue to ensure staff complete full risk assessments for women and birthing people on arrival to triage, using an assessment tool, and monitor these to ensure staff compliance.
- The service should continue to ensure the entire WHO checklist process is fully embedded and compliance is maintained.
- The service should ensure staff monitor, manage and document CTG findings, including “fresh eyes” checks, and escalate risks appropriately.
- The service should ensure all risks are identified and included in risk registers to ensure efficient management and mitigation of all risks to people, including staff, and the provision of care.
- The service should continue to ensure all policies, processes, and clinical guidelines are reviewed regularly to ensure the most up to date guidance and information is provided to staff.
- The service should continue to ensure all staff are aware of the location of emergency medicines for all wards and treatment areas.
- The service should continue to address staff retention and sickness levels.
- The service should make sure that staff report all births outside of labour ward so that leaders are assured that women and birthing people are in a safe place for childbirth.
- The service should ensure there is sufficient and appropriate support for staff and processes throughout the unit after hours.
- The service should continue to monitor stillbirth rates and ensure recommendations and learning from internal and external reviews are carried out effectively.
- The service should ensure a just and safe culture to support staff in their work.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.