Imperial College Healthcare NHS Trust

St Mary's Hospital

Inspection report

The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY
Tel: 02033113311
www.imperial.nhs.uk

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

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	Good
Are services well-led?	Good

Our findings

Overall summary of services at St Mary's Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Imperial College Healthcare NHS Trust.

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

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

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

We did not review the rating of the location therefore our rating of this hospital stayed the same

St Mary's Hospital is rated requires improvement.

Our rating of maternity services stayed as outstanding overall.

St Mary's Hospital including the co-located Lindo Wing provided maternity services in the hospital and community to approximately 4,000 women in Paddington and surrounding areas. The maternity service provided consultant-led and midwife-led care for both high and low risk women. The hospital also offered a wide range of services and specialist care within maternity services. This included a consultant-led labour ward, birth centre, an outpatient antenatal clinic, a fetal medicine unit (FMU), a maternity day assessment unit (MDAU), a triage unit, antenatal and postnatal inpatient wards (including transitional care), perinatal services and bereavement services. There was a level 2 neonatal unit at St Mary's Hospital providing special care (14 cots), high dependency and intensive care (8 cots) for babies born prematurely or with low birth weight.

The Lindo Wing, also provided a labour ward with one theatre, 11 postnatal beds and an antenatal clinic. Women who received private care also benefitted from access to the NHS services at St Mary's hospital, if required.

We also inspected one other maternity service run by Imperial College Healthcare NHS Trust. Our reports are here:

Queen Charlotte's and Chelsea Hospital – https://www.cqc.org.uk/location/R1H41

How we carried out the inspection

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

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

Outstanding ☆ →←

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

- Staff had training in key skills and worked well together for the benefit of women and birthing people. They understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to most women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The leaders had recognised and acted upon the challenges of providing sufficient midwifery staffing and in 2022 had commenced a taskforce to improve recruitment and retention.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services.

However:

- At the time of the inspection in triage we found there was an inconsistent approach to the recording of patient's risk assessments and prioritisation of their care. This was immediately responded to by the trust who reviewed and amended new guidelines and processes.
- Action to improve issues identified on skills and drills for baby abduction procedures were not acted upon in a timely way.

Is the service safe?

Good ● →←

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing and midwifery staff received and kept up-to-date with their mandatory training. More than 90% of staff had completed all 12 mandatory training courses against a trust target of 90%. Two practice development midwives and two preceptorship lead midwives supported midwives across both sites.

Medical staff received and kept up-to-date with their mandatory training. Nearly 98% of doctors in training and nearly 100% of consultants had completed all mandatory training courses.

Maternity

The service made sure that staff received multi-professional simulated obstetric emergency training. Data provided by the trust shows all clinical staff received obstetric emergencies skills training and completion rates above 90% for both midwives and medical staff. Completion of PRactical Obstetric Multi-Professional Training (PROMPT) was monitored by the trust's practice development midwives and local leads were notified about required training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labor. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Staff at the private Lindo Wing attended the same comprehensive training.

Although training practices were good overall, we identified scenarios where there was a need to develop/improve the trust's skills and drills to better support the safety of women and babies in an emergency. For example, staff told us women were able to use the ensuite-bath on the Lindo Wing's delivery suite during early labour, although this was rarely used. The bath was partially enclosed, which added to the risk and complexity if moving and handling support was required. Whilst there were some trust mitigations in place to ensure they promoted women's safety, skills and drills were not carried out with staff to rehearse their emergency response, if for example, a woman needed to be evacuated from the bath quickly. Since our inspection visit the trust has told us the bath is considered redundant and they are looking at removing it.

After the site visit, the trust sent assurances to CQC they had organised bespoke training to commence on 14 March 2023 with the midwifery team in collaboration with the physiotherapy department and practice development facilitator to assure staff competency in bath evacuation.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts so they knew when to renew their training. Imperial Private Healthcare staff who worked on the Lindo Wing were subject to the same training requirements as their NHS colleagues and compliance was monitored centrally by the trust. The Imperial Private Healthcare leadership team also monitored training compliance on Lindo Wing via their own system dashboard, which provided a line-by-line detailed summary with individual staff names and any training modules they had outstanding.

Safeguarding

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

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

Staff could give examples of how to protect women 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.

Maternity

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. Where safeguarding concerns were identified, staff developed birth plans with input from the safeguarding team to keep women and birthing people safe. Staff followed the baby abduction flow chart and undertook baby abduction drills.

On the Lindo Wing the last abduction drill was completed on 1 December 2022. This drill identified practises in the unit could be improved and there was an 'immediate' action recorded to repeat the drill in 3 months to re-check the effectiveness of the abduction policy. Following our inspection, the service stated this was not an 'immediate' action and considered the timeframe of the next drill would be until the end of March. However, the next completed drill provided was 16 June 2023. Therefore, the service had not acted on this recommended action in a timely manner as they had also identified issues with a person being unchallenged and being able to enter different areas of the service at the previous 2 drills.

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

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 trust's safeguarding team supported staff and were accessible when needed. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

During the inspection we observed staff followed safe visiting procedures. Staff were aware of requirements per the trust's baby abduction policy, and we saw how ward areas were secure, and doors were monitored.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Leaders completed regular infection prevention and control and hand hygiene audits. Cleaning scores between December 2022 and February 2023 showed staff consistently performed well for cleanliness. Where there were exceptions, the trust implemented a cleaning action plan to address identified concerns. Data showed hand hygiene audits were completed monthly in all maternity areas. Many areas achieved scores of greater than 95% compliance each month.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff continued to wear masks in clinical areas and made sure their clothing ensured they were bare below the elbows. Leaders monitored the rates of hospital-based infections, which showed very low or no incidents of common transmissible bacteria, such as E Coli, MRSA or Clostridium Difficile.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and applied 'I am clean' stickers, which showed other equipment was clean and ready for use.

Maternity

Environment and equipment

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

The design of the environment at St Mary's hospital followed national guidance and supported patient flow. The maternity units at St Mary's Hospital and the Lindo Wing were fully secure. There was a monitored buzzer entry system to the maternity units and reception areas in St Mary's Hospital were staffed 24 hours a day, 7 days a week. The service had dedicated maternity theatres and transitional care beds for women, birthing people and babies requiring a higher level of monitoring after delivery.

Staff had developed a bereavement suite at the end of the delivery suite, which women and birthing people could access and leave from without going through the delivery suite. The suite included two rooms, one for delivery and the other decorated in a comfortable, home style area for women and their partners to rest in. This was a recommendation in the Sands position statement (Bereavement care rooms and bereavement suites 2016). Although there were no specific facilities in the Lindo Wing, private patients had the same rights of access to St Mary's hospital's bereavement facilities.

The service had enough suitable equipment to help staff safely care for women, birthing people and babies. During the inspection we reviewed specialist equipment, including emergency adult and neonatal resuscitation equipment and observation equipment. We found daily checks were carried out consistently by the trust and equipment was serviced at appropriate intervals.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. We saw that call bells were within easy reach and staff responded quickly when these were rung.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. Partners were able to stay overnight with women and birthing people as this had been reinstated following suspension of the practice during COVID-19.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. In the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph (CTG) machines and observation monitoring equipment.

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 completed risk assessments but not in every area was guidance clear enough to take appropriate action to remove or minimise risks. Staff identified and acted quickly upon women at risk of deterioration.

Maternity

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

Out of hours calls were automatically redirected to triage and were answered on average within 8 seconds. Calls redirected to triage by the helpline were answered within 11-13 seconds. In the three months before this inspection the maternity helpline had received a total of 10,981, of which 1,666 calls were abandoned (15.2%) and the average response time was 7.14 minutes. The trust was looking at whether additional staff were required for the helpline during the day to reduce abandoned calls and waiting times for answering calls.

The trust also provided us with 2 other audits of phone calls received by the triage unit, carried out in October 2022 and January 2023. These audits identified staff in the triage units answered over 500 calls each month. There were no issues with direct phone calls to the triage unit, as staff responded within 2.3 minutes on average.

We found that the system to prioritise women and ensure they were seen in the correct timeframe did not accurately capture how long women waited between being checked in and being seen by a midwife. An obstetric triage system had been partially put in place in maternity triage to reduce risks to women and ensure they were seen by the appropriate staff in a timely way. Staff had completed an audit in January 2023 regarding triage waiting times, which recommended that documentation to capture these assessment times needed further improvement.

We also found that there was inconsistent guidance and understanding of time frames regarding when women should be seen by medical staff after a midwife had seen them. Staff quoted different time frames, although the trust's guidance at the time of inspection advised staff to 'urgently' or 'immediately' get a medical review.

Our findings were raised with senior leaders at the end of our site visit. They immediately reviewed the guidance and amended a maternity risk assessment tool, priority guide and escalation pathways and included them in the amended triage guidelines. They explained with the full implementation of the triage system staff would use an electronic whiteboard which displayed arrival, triage, and treatment times, along with priorities. The trust confirmed that following the agreement of the proposed business case in April 2023, they would commence staff recruitment which would allow them to have system embedded by January 2024.

The Lindo Wing did not have a triage system as women or birthing people contacted their consultant obstetricians or the delivery suite directly. There were no reported delays to the delivery suite and as there was a separate pathway for private patients, women and birthing people did not access triage at St Mary's Hospital.

Staff identified and quickly acted upon women and birthing people at risk of deterioration We reviewed 8 maternity care records. Risk factors were highlighted, for example, women and birthing people with a high body mass index, living in a deprived area, or those with comorbidities. All women and birthing people were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a nationally recognised tool to identify women and birthing people at

risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. National guidance on 'fresh eyes' checks require a second check to review Cardiotocographs (CTGs) every hour. The service completed regular audits of patient records to check clinical observations were fully completed and escalated appropriately.

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 completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used a SBAR tool (situation, background, assessment and recommendation) when carrying out patient transfer

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.

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

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

The service provided transitional care for babies who required additional care.

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

Midwifery Staffing

Maternity

The service had enough maternity staff, although there was high levels of sickness in some areas. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most of the time, the service had enough nursing and midwifery staff to keep women, birthing people, and babies safe. On the day of inspection midwifery staffing numbers were at an acceptable level. There was only one midwife, initially, working in triage, although this increased later in the day when the unit became busier and showed managers monitored and responded to changes in busyness.

The most recent assessment (July 2022) of the recommended safe staffing ratios for the maternity service compared favourably to BirthRate Plus working fulltime equivalent (WTE). The overall ratio was 23 births to 1 WTE midwife, which the trust state they have been compliant with from 1 July to 31 December 2022.

Staffing levels were well managed on both the Lindo Wing and St Mary's Hospital sites. Data supplied by the trust showed women received timely care. In the last 12 months all patients received one to one care in labour and there were no reported delays in inductions of labour or planned procedures.

Staff 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. Information from the trust showed the Lindo Wing had no red flag events in the last 12 months and St Mary's Hospital had no red flag reporting for staff shortages since August 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2023. This review advised there was no change to recommended staffing levels from the full BirthRate Plus review in July 2022.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. From 1 July to 31 December 2022 the compliance rate reported for one-to-one care was 98-100%. Rosters for labour wards were planned to always allow for one supernumerary coordinator. The trust reported there had been two occasions at St Mary's Hospital in the previous six months when this did not occur due to short term sickness.

Ward managers could adjust staffing levels daily according to the needs of women and birthing people. The service had a twice-daily staffing report meeting attended by managers from across the site. Managers moved staff according to the number of women and birthing people in clinical areas but staff told us this was at short notice and they were expected to work in areas unfamiliar to them.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. In response to the workforce challenges the trust had set up a midwifery recruitment taskforce and a retention subgroup in 2022, who were looking at flexible working patterns and self-rostering by staff to improve retention. Their initial aim was to recruit at least 10 band 6 experienced midwives over the year but had exceeded this with 13 recruited. A recruitment and

retention midwife had been appointed; a maternity bleep holder team was established of 5 full time staff who had oversight of both hospitals. The units had twice daily maternity staffing huddles, staff worked across site, a senior midwife on call rota, and redeployment of specialist midwives and the senior team into clinical shifts. A business case was in progress to request additional lists for the increased caesarean section trends.

Staff in the Lindo Wing told us sickness rates were increasing as staff became more stressed, although information showed this had begun to reduce to just under 10% in the two months before our inspection. The senior management team had reinstated meetings to discuss reasons for the level of sickness and to offer support to staff.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. Data showed 84 % of maternity staff had received a yearly appraisal at March 2023. Managers made sure staff received any specialist training for their role.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. Staff said the service had enough medical staff to keep women and babies safe on labour ward. The consultant onsite cover was from 8am to 8pm 7 days a week (84 hours cover per week). There was a consultant rota for offsite cover for labour ward and the consultants had remote access to patient records and all lived within half hour travel of the hospitals. The rota ensured that consultants were present and available for direct or indirect supervision.

The data supplied by the trust showed that the Lindo Wing establishment included 14 WTE permanent consultants. There was anaesthetic cover available 24 hours a day and 7 days a week.

An audit undertaken against The Compliance with Royal College of obstetrics and Gynaecology workforce document 'Roles and Responsibilities of a Consultant Obstetrician & Gynaecologist' from August to December 2022, demonstrated substantial assurance that a consultant was present for all clinical situations when a consultant was required to attend in person. Except for those which took place out of hours, where the senior trainee was deemed competent and felt confident to undertake the procedure/delivery.

The service had a good skill mix of medical staff on each shift and managers reviewed this regularly. The consultants ensured an on-call rota for junior doctors was completed for each shift. The audit included a survey of senior house officers and registrar doctors to determine whether senior trainees had felt adequately supported by consultants whilst on-call. The registrars confirmed very good support from the consultants, and they always attended out of ours if requested. The senior house officers had a mixed response most stating they were very or somewhat satisfied with senior support.

Maternity

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 only used trust staff as locums and did not use external or agency locums.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Appraisal rates for consultants and junior medical staff were above 90%.

Records

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

Women and birthing people's notes were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 8 sets of records and found records were clear and complete. We found there was consistent recording throughout women and birthing people's maternity journey. Areas such as fetal movements, carbon monoxide monitoring and women's wellbeing were all recorded appropriately.

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

The maternity services scorecard for December 2022 showed that 100% of women had a personalised care plan in place.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Clinical staff had access to women and birthing people's records and could access these from different areas around the hospital sites. Paper records were kept in the same area as women or birthing people when they visited the hospital.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 11 prescription charts and found staff had correctly completed them.

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.

Staff completed medicines records accurately and kept them up-to-date. Medicines records we saw were clearly recorded and up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all 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 and stored at the correct temperature. Staff checked controlled drug stocks daily. 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. Medicines recorded for the 11 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had one 'never' event in the last 12 months. This occurred in the theatres at St Mary's Hospital, which was caused by failure of the operating team to complete the WHO checklist prior to Caesarean section. Learning from the event was shared across sites and lead to reminding staff at the post graduate forums and multidisciplinary meetings of the importance of completing the WHO checklist. WHO checklists were completed appropriately during our visits to theatres in the Lindo Wing and St Mary's Hospital.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. For example, the trust had reported 15 incidents to the Healthcare Safety Investigation Branch (HSIB) for investigation. Nine cases had been accepted, of which 7 had been completed with 2 of these occurring at St Mary's Hospital. We saw action plans were implemented in response to the HSIB findings, the progress of the action plans was monitored through the maternity and quality and safety committee, and information was cascaded to staff through the maternity safety newsletter.

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.

Maternity

Staff received feedback from investigation of incidents, both internal and external to the service. Staff discussed serious incidents and shared learning at an obstetric clinical governance meeting and leaders reminded staff of the importance of declaring the urgency of an emergency instrumental delivery. Feedback was also shared by managers, through a newsletter, learning information displayed in staff rooms, and during the safety huddles.

There was evidence that 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. Staff told us that managers spoke to and supported them after any serious incident.

Is the service well-led?

Good 

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

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Maternity services at St Mary's Hospital were managed as part of the Women's Services – Maternity directorate. The Women's Services – Maternity directorate across the trust was managed by a triumvirate of Clinical Director, General Manager and Associate Director of Midwifery. They were supported by a range of staff including, Head of Midwifery, 12 matrons, obstetric heads of specialty and business managers. The private wing of St Mary's Hospital (the Lindo Wing) was managed by a Director, a Divisional Director of Nursing and Midwifery, a Clinical Director, a Lead Nurse and Director of Operations, although this post was vacant. The Lindo Wing also has a lead midwife.

The service had undergone a significant change in maternity leadership since early 2020, including 2 lead roles for division of Women's and Clinical Support, the entire maternity triumvirate, the lead midwife for governance and risk and the labour ward matron. Leaders advised that despite this potential for an adverse impact to the service they continued to operate at normal activity levels throughout the pandemic.

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

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

The executive team visited wards on a regular basis. Staff told us they saw the executive team and senior managers, and spoke of how accessible and encouraging they were. One staff member told us there had been increased positivity since new management were put in place. They felt empowered and this gave them permission to lead.

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

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

Vision and Strategy

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

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

Imperial Private Healthcare's strategy for the Lindo Wing focused on 4 key priorities; maximising patient experience by listening/ acting on patient feedback; striving for the best clinical quality in maternity services; workforce optimisation; and financially growing the business. Staff could explain the vision and what it 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 planned to revise the vision and strategy to include these recommendations. Delivery of the trust's Ockenden action plan had been included in their strategy for 2023. Updates were regularly mentioned as part of monitoring and governance processes, such as the Divisional Quality and Safety Committee meetings and the executive management board quality group.

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

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

Culture

Maternity

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

Staff felt respected, supported, and valued**.** Staff were positive about the hospital, its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff told us they were happy at work, and were supported by other staff. One staff member told us the relationships between consultants and midwives were, “Very good.”

We spoke to staff across most grades and disciplines. Staff on the Lindo Wing reported an improving working culture and that multidisciplinary teams worked closely, respected each other, and were united to improve outcomes for women and their babies. During the inspection the divisional director of nursing told us historically there had been concerns about poor staff culture on the Lindo Wing, but felt they were now on an improvement trajectory because of recent actions the leadership team had taken.

In 2022 the trust’s senior leadership commissioned an internal and external review to further understand their concerns about the culture on Lindo Wing and its potential impact on staff. The outcome of the external review found evidence of nepotism and favouritism, with a possible discrimination profiling element. Following on from this external review, the senior leadership made changes to resourcing of the service, behavioural frameworks and conflict resolution processes. They recalibrated the roles of Band 7s to better support them to develop into leadership roles and were also taking further steps to tackle sickness rates and improve staff well-being. The Divisional Director of Nursing and Midwifery said this had impacted positively on staff culture but were awaiting the results of the 2023 staff survey for measurable data on staff culture. The results of staff survey were expected at the end of February 2023.

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

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

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

Maternity

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. These included Directorate Performance Support meetings, Executive Management Board Quality Group meetings, and Maternity Oversight meetings. Lindo Wing's maternity clinical governance was joined up with the maternity directorate in the Women's and Clinical Support division. Meeting minutes show these were well attended and discussions included updates on how the service was performing in relation to national guidance and audits, the risk register for maternity and serious incident learning.

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

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Monthly quality and safety meeting minutes showed guidance that needed to be reviewed was identified and returned to the meeting to be ratified once reviewed, although it did not detail which specific guidance this related to.

We reviewed clinical guidance, including those for triage and reduced fetal movements, which were in date.

Management of risk, issues and performance

Maternity

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues but not all issues had 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.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry). With the exception of the maternity dashboard, Lindo Wing was also captured in the same data and reporting along with the rest of the maternity service in the Women's and Clinical Support division.

As part of the National Maternity and Perinatal Audit the trust looked at how many women and birthing people had been supported with written information or a conversation about reduced fetal movements. Data for St Mary's Hospital showed staff recorded this had been completed in 89% to 99% of records between July and October 2022. The audit identified the need to continue to remind and encourage staff to signpost women to the different resources available on this subject in different languages and methods of access, i.e. leaflets, online apps or videos.

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. Managers monitored outcomes on maternity scorecard, which provided statistical information on a monthly basis. When these statistical figures were outside national standards, they were discussed at risk meetings to ensure appropriate actions were taken to improve. The Lindo Wing did not contribute to the trust's maternity dashboard submission, but they utilised their own system for monitoring patient outcomes. Data supplied by the trust showed caesarean sections by category 1, 2 and 3; on average were all completed within timeframes which complied with national guidelines.

However, at the time of inspection we identified a risk around prioritisation of women and birthing people attending triage. The lack of prioritisation evidenced in audits had not been fully acted upon while the service was awaiting the implementation of BSOTS (a triage assessment tool) and new patient computer software. This was rectified immediately following our inspection.

Concerns in areas such as the length of time it took for calls to be answered or whether calls had been abandoned were identified when the trust provided data for the 3 months before this inspection. These showed over 15% were abandoned and average wait times for calls to be answered averaged longer than 7 minutes. The service had identified an action to continue to assess whether additional staffing was required to reduce call waiting times and abandoned calls. We were aware before this inspection of an incident resulting in a fetal death where calls to the telephone triage had not been answered. One of the actions following the incident in August 2022 was to review the trust's maternity helpline service.

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

Staff on the Lindo Wing carried out bi-annual audits of patient records to determine whether clinical observations were assessed and recorded in line with MEOWS. Records audited between October 2022 and January 2023 achieved a

satisfactory compliance score of 90%. The trust also carried out regular audits of staff compliance with fresh eyes. In the most recent audit, staff in the Lindo Wing achieved a compliance score of 79% and in St Mary's 89% compliance by midwives and 100% by medical staff, against a trust target of 85%. Other audits completed, included for maternal readmissions and for reduced fetal movements.

Managers shared and made sure staff understood information from the audits.

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

The trust had a maternity risk register for those risks

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Information Management

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

The service collected reliable data and analysed it**.** The trust 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.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service had a digital midwife who was able to support staff to navigate the system at St Mary's Hospital and a digital midwife dedicated to data validation who worked across the service. They were also able to pull data from the system to support the trust analysis of performance. The trust had a strategy to reduce the amount of paper records used and fully implement their electronic system.

The information systems were integrated and secure**.** The trust used both a digital recording system, which staff in all areas of the service had access to. Staff were required to log in and out electronically before being able to see records.

Data or notifications were consistently submitted to external organisations as required. Staff made referrals to external organisations, such as the Healthcare Safety Investigation Branch (HSIB), following serious incidents.

Engagement

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

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

holding listening events. Meeting minutes showed the MVP had started work on developing promotion of events to targeted groups, they had relayed feedback from women and birthing people they had spoken to, identified concerns that needed to be addressed immediately and offers of support to ensure information was inclusive of all gender groups.

The Lindo Wing senior managers did not use the local MVP as it was not compatible with their operating model. Instead, they used their own mechanism for gathering patient feedback known as 'listening to mothers'. Ninety-one percent of respondents noted no areas for improvement with the maternity service and 98% would recommend the service to friends and family and felt they were treated with respect and dignity. The trust's project findings were positive, but where they had identified improvement in areas, we saw trust action plans were in place.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The trust had an onsite interpreting service that covered the 5 most spoken languages other than English by women and birthing people who used the service. The interpreting service were based in an easily accessible part of the hospital complex and staff visited areas where their interpreting services may be most required, such as the female genital mutilation (FGM) clinic. Staff also had access to Language Line, a telephone interpreting service.

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

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. They had carried out a trial of an interpreter on wheels service (a tablet on a mounted platform) that enables interpreters throughout the world to assist with interpreting by video and audio streaming. The service was also waiting to start a North West London sector wide pilot for a communication tool to improve the transfer of information between healthcare providers, staff and patients.

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

The trust had responded to the Helping Our Teams Transform (HOTT) report and looked to make improvements by:

- Submitting a business case for all day caesarean section lists to be extended

Maternity

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

Outstanding practice

We found the following outstanding practice:

- The trust had a female genital mutilation (FGM) clinic, which offered counselling for trauma for approximately 8 women each week, the counselling covered defibulation, emotional support on childbirth and social support.
- The clinic had a Somalian Muslim advocate who signposted women to community groups for their future wellbeing and provided information about domestic violence and safeguarding.

Areas for improvement

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

Action the trust SHOULD take to improve:

St Mary's Hospital

- The trust should monitor the implementation of all reviewed or newly amended policies and procedures in regard to the triage. (Regulation 12)
- The trust should continue to ensure all women who present at triage are assessed by a midwife following the triage in maternity guidelines. (Regulation 12)
- The trust should ensure that all staff complete regular skills and drills training in relation to removal of woman or birthing person from any equipment they may use, such as a bath. (Regulation 12)
- The trust should ensure that action to reassess concerns identified in baby abduction drills are carried out in a timely way. (Regulation 12)

Our inspection team

The team that inspected the service comprised of 2 CQC lead inspectors (one at St Mary's Hospital and one at the Lindo Wing), 2 second CQC inspectors, a CQC specialist adviser team of 3 midwives and 2 consultant obstetricians. The inspection team was overseen by Carolyn Jenkinson Deputy Director of Secondary and Specialist Healthcare