London North West University Healthcare NHS Trust

Northwick Park Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Northwick Park Hospital

Requires Improvement 

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow.

London North West University Healthcare NHS Trust operates hospital services from three main hospital sites:

- Northwick Park Hospital
- Ealing Hospital
- Central Middlesex hospital.

The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust was last inspected in 2019 and was rated requires improvement overall.

The trust provides, urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people services, end of life care and outpatient services.

The trust provides a range of community services including: dental services, sexual health services, paediatric audiology, musculoskeletal specialist and end of life care.

We inspected one core service at Northwick Park Hospital.

Our inspection was unannounced to enable us to observe routine activity. Before the inspection we reviewed information we had about the trust based on the intelligence we had received.

We carried out an unannounced inspection of the maternity service on 25 and 26 October 2021 at Northwick Park Hospital to follow up the concerns we identified at our previous inspection of the service in April 2021 where we had rated safe and well led as inadequate.

Maternity Services:

Our rating of this maternity services at Northwick Park Hospital improved. We rated this service as Requires Improvement overall at this inspection. We rated safe, responsive and well led as Requires Improvement. We rated effective and caring as Good. We rated it as requires improvement because:

- The service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Waiting times were longer for women across maternity services when staffing levels were low.
- Mandatory training compliance was still not in line with the trust target of 85%. At 84% compliance, this did not meet the trust target of 85% but was an improvement on previous compliance.

Our findings

- Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.
- There was some out of date equipment on resuscitation trolleys and cold cots had been out of operation for two months.
- We saw loose triage log sheets which could become detached from women's notes and meant that information could be misplaced. Records when staff had spent 'Time alone' with women were still not always being recorded at every antenatal appointment.
- We found an open trolley on the delivery suite which contained two drugs vials. There was a risk that unauthorised people could have access to the vials.
- Antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. We were told that videos and online classes had been planned, but these had not been implemented.
- The triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had previously called.
- Staff on the maternity day assessment unit (DAU) told us there was no clear policy or pathway for women that should go to triage and women that should go to DAU.

However:

- New interim leaders had the skills and abilities to run the service. The new managers understood and managed the priorities and issues the service faced. However the trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team.
- In response to external reviews of the service, managers had produced a maternity improvement plan, this was reviewed and updated weekly.
- There had been improvement in doctors, nurses and other healthcare professionals working together as a team to benefit women.
- Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.
- Staff on triage used the modified early obstetric warning score (MEOWS).
- Work was in progress to monitor domestic abuse being assessed at all antenatal appointments.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had information boards which carried updates for staff on the maternity risk register.
- Policies and clinical guidelines we viewed were up to date and had dates for review.
- The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and development.
- The service had recently employed an audit midwife and a risk midwife to ensure monitoring of patient outcomes and benchmarking of service provision.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Our findings

- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Professor Edward Baker Chief Inspector of Hospitals

How we carried out the inspection:

We visited maternity services at Northwick Park Hospital on 25 to 26 October 2021. During the inspection we visited the labour ward, postnatal and antenatal areas, admission triage area, day assessment unit and theatres. We conducted interviews with staff members on the 25 and 26 October 2021. We spoke to 31 staff including service leads, matrons, midwives, medical staff and maternity care assistants. We also reviewed the trust's performance data and looked at trust policies for the maternity service. You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement 

Our rating of this maternity services at Northwick Park Hospital improved. We rated it as requires improvement because:

- The service did not always have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Waiting times were longer for women across maternity services when staffing levels were low.
- Mandatory training compliance was still not in line with the trust target of 85%. At 84% compliance, this did not meet the trust target of 85% but was an improvement on previous compliance.
- Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.
- There was some out of date equipment on resuscitation trolleys and cold cots had been out of operation for two months.
- We saw loose triage log sheets which could become detached from women's notes and meant that information could be misplaced. Records when staff had spent 'Time alone' with women were still not always being recorded at every antenatal appointment.
- We found an open trolley on the delivery suite which contained two drugs vials. There was a risk that unauthorised people could have access to the vials.
- Antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. We were told that videos and online classes had been planned, but these had not been implemented.
- The triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had previously called.
- Staff on the maternity day assessment unit (DAU) told us there was no clear policy or pathway for women that should go to triage and women that should go to DAU.

However:

- New interim leaders had the skills and abilities to run the service. The new managers understood and managed the priorities and issues the service faced. However the trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team.
- In response to external reviews of the service, managers had produced a maternity improvement plan, this was reviewed and updated weekly.
- There had been improvement in doctors, nurses and other healthcare professionals working together as a team to benefit women.
- Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.
- Staff on triage used the modified early obstetric warning score (MEOWS).
- Work was in progress to monitor domestic abuse being assessed at all antenatal appointments.

Maternity

- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had information boards which carried updates for staff on the maternity risk register.
- Policies and clinical guidelines we viewed were up to date and had dates for review.
- The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and development.
- The service had recently employed an audit midwife and a risk midwife to ensure monitoring of patient outcomes and benchmarking of service provision.
- It was easy for people to give feedback and raise concerns about the care they received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with it.

- During our previous inspection in April 2021, we found staff were not compliant with the trust's 85 % mandatory training target. During this inspection we found the overall rate had improved. During this inspection we found that the trust had taken action to improve the overall compliance rate despite the challenges of the COVID-19 pandemic. The trust sent a maternity services dashboard dated 2 November 2021. This showed that overall divisional compliance with mandatory training was 84% which was an improvement from the last inspection but was below the trust target of 85%.
- Mandatory training included fire safety, infection control, safeguarding adults at risk and safeguarding children levels one to four, equality and diversity, health and safety, information governance, and resuscitation basic life support (BLS).
- The overall compliance rate for midwifery staff was 81%. This was below the trust's 85% target. The modules where compliance was below the trust's mandatory training target were: fire safety (72%); manual handling level 2 (76%); resuscitation BLS (63%).
- Medical staff received mandatory training, but some were still not up to date. The overall compliance rate for medical staff was 83%. One module was below the trust's 85% target, this was resuscitation BLS (63%). However, the overall compliance rate was an improvement on medical staff mandatory training rates at the time of our previous inspection in April 2021.
- Mandatory training met the needs of women and staff. Mandatory training and learning updates were provided weekly to staff. Records of attendance were in place and reviewed weekly. Staff non-compliance with mandatory training was dealt with individually.

- The service had a maternity practice learning team. However, the trust's learning and development team, not the maternity practice learning team, monitored mandatory training compliance. Staff received a notification from the trust's learning and development team when training was due to be updated. Staff told us their line managers also received a notification to inform them when their training was due to be updated.
- Following our inspection, the service informed us that there was a plan to ensure compliance. However, we were not provided with the plan.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Although not all staff were up to date with safeguarding training, staff knew how to recognise, and report abuse and they knew how to apply it.

- The service had a designated team of safeguarding midwives. This team consisted of two named professional team leads and five band 7 midwives including the Female Genital Mutilation (FGM) midwife. All staff received level 2 safeguarding adults and safeguarding children training. Clinical staff received level 3 safeguarding adults and safeguarding children in accordance with intercollegiate guidance 2019 and 2020.
- Staff we spoke with knew how to identify adults and children at risk of abuse and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to inform if they had concerns.
- The service's mandatory training spreadsheet dated 2 November 2021 showed that the trust's 85% target for all safeguarding mandatory training was not always met. For example, midwifery staff were not meeting the standard for safeguarding adults' level 2 (80%) and safeguarding children level 3 (70%).
- Healthcare assistants were not meeting the trust target for safeguarding adults' level 2 (70%) and safeguarding children level 3 (56%).
- Medical staff were not meeting the trust target for safeguarding adults' level 2 (80%) and safeguarding children level 3 (70%). This meant the trust could not be assured that all staff had up to date safeguarding training specific for their role.
- All staff could book safeguarding supervision with the maternity safeguarding team. Staff could use these sessions for support if they were working with a woman or baby where safeguarding risks had been identified.
- Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff told us women with safeguarding risks and a language barrier or sensory loss would always be offered face to face interpreting services.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust had a dedicated safeguarding nurse on duty, 24 hours a day, seven days a week. Staff also had access to local safeguarding agencies' contact details on the trust's intranet.
- Staff told us they completed child sexual exploitation training as part of the level 3 safeguarding training.
- The service had two midwives that led on domestic abuse, part of their role was to complete spot checks and record reviews on safeguarding and domestic abuse. At the time of inspection an audit of domestic abuse was in progress.
- During our previous inspection in April 2021 we were not assured domestic abuse was addressed at all antenatal appointments. In response, maternity services completed a spot check audit of antenatal records in May 2021 to review compliance with risks from domestic abuse being recorded at all antenatal appointments. Learning from the audit led to the service highlighting the recording of domestic abuse at team meetings and in risk newsletters. The

service also scheduled a re-audit of domestic abuse in response, this was completed in September 2021. However, results of this audit were unavailable at the time of inspection. The domestic abuse audit was scheduled to be reviewed at the maternity unit meeting in October 2021 and the maternity clinical governance meeting in November 2021. Domestic abuse recording at every antenatal appointment was on the maternity services' risk register.

- Community midwives received prompts when booking appointments for women. These prompts included whether domestic abuse had been discussed. Community midwives had an electronic risk tool they used with antenatal and breast-feeding women. Staff told us they could not progress appointments unless social issues had been discussed and the electronic record completed.
- Community staff told us they used to have stickers for 'Time Alone'. Community midwives said the stickers indicated on women's records when community midwives had spent one to one time with them, but the stickers had been withdrawn. Community midwives said the stickers were a useful prompt when working in the community, as they were a visual reminder to discuss social issues with women at every appointment.
- The service had a lead midwife for female genital mutilation (FGM). All midwifery and medical staff were trained in recognising and safeguarding women at risk of FGM.
- Staff followed the baby abduction policy and undertook baby abduction drills. There was an up to date baby abduction policy in place. The maternity practice learning team monitored 'skill drills' for baby abduction. Staff we spoke with could describe the procedure in the event of a baby being abducted from the maternity service, including alerting security and closure of exits and entrances to the hospital.

Cleanliness, infection control and hygiene

Staff did not always observe control measures to protect women, themselves and others from infection. Some equipment marked as clean had surface dust.

- Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbows and observed hand hygiene procedures. Staff had access to adequate supplies of PPE. There were appropriate facilities for hand washing and adequate supplies of hand gel available to staff and the public. Guidance on donning and doffing PPE was available to staff across maternity services.
- Equipment we checked throughout the inspection had up to date safety testing, including resuscitaires, defibrillators and blood pressure machines. Curtains were clean and in date.
- Cleaning records were up to date. The service generally performed well for cleanliness. The nominated clinical lead completed regular 'walk arounds' with the cleaning services auditor. The results of these audits were displayed in clinical areas on cleaning information boards. For example, the antenatal unit had 97% compliance with cleanliness audits in September 2021 and October 2021. In the same period the delivery suite compliance was 98% in September 2021 and 99% in October 2021. The postnatal ward (Florence ward) had 99% compliance in September 2021 and October 2021.
- During our inspection we found equipment had been labelled with 'I am clean' stickers on the delivery suite. However, we found the tops of the fetal blood testing trolley and resuscitation trolley were dusty, even though they had stickers applied.
- In the birth centre we found the underside of a cot in pool room 2 was dusty, although the upper-side of the cot was clean. We also found dust on the resuscitation trolley in the antenatal clinic. This meant there was a risk of staff using equipment that was not thoroughly cleaned, due to the equipment having stickers indicating it had recently been cleaned.

- The service had a member of staff on duty at the main entrance to the maternity unit who conducted temperature checks and provided visitors with masks and hand gel. There were also staff at Northwick Park Hospital's main entrance conducting the same checks.
- We reviewed hand hygiene audit information for maternity services from April to October 2021. We found the lowest rate was on the birth unit (Edith ward) on the 19 September 2021 at 60%. However, there was improvement in subsequent weeks with the rate on 22 October 2021 at 100%. The hand hygiene audit for the postnatal ward (Florence ward) fluctuated between 70% on 29 August 2021 and 22 October 2021 and 100% from 14 May 2021 to 16 June 2021, as well as 16 August 2021 and 13 September 2021. All other weeks in the period were between 80% and 90%. The labour ward had 100% compliance from 31 April 2021 to 29 September 2021. This was an improvement from the previous inspection in April 2021, when compliance rates across maternity services had ranged between 70% and 80%.
- We saw hand hygiene technique posters displayed across wards and clinics.
- Women were required to do a lateral flow test (LFT) for COVID-19 on arrival at the maternity unit. Women testing positive for COVID-19 were isolated. Isolation rooms had clear signage on doors to alert staff of infection control procedures.

Environment and equipment

Overall, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, there was out of date equipment on resuscitation trolleys and cold cots were not operational.

- The service had suitable premises and equipment to care for women and babies and keep them safe. Women could reach call bells and staff responded quickly when called. Treatment rooms and clinic rooms were uncluttered, organised and accessible. Sharps bins were signed and dated.
- Staff carried out daily safety checks of specialist equipment. Emergency trolleys were available in every area of the department. Trolleys were checked daily and weekly, and records we viewed were up to date. However, we found out of date items on a trolley in room 8 on the antenatal ward, including blood collection sets and antiseptic solution.
- We found that the two birthing pool rooms in the birth centre had twice daily checks completed on their resuscitation trolleys. We found out of date tracheotomy tubes on trolleys in both birthing pool rooms. On the neonatal unit (NNU) equipment on the resuscitation trolleys was in date, except for two out of date carbon dioxide (CO2) detectors, which were dated July 2021. We drew this to the attention of staff during the inspection and saw that staff removed out of date equipment and replaced the CO2 detectors immediately.
- Maternity services had two surgical theatres. Both theatres were available 24 hours a day, seven days a week. If the theatres were in use, staff told us women could be transferred to the hospital's main theatres.
- Cold cots in the bereavement suite were not operational, due to failure of the cots' cooling systems. This meant bereaved parents might not be able to spend enough time bonding with their babies. (Cold cots slow down the natural changes in the body after death). Staff said the cots had been out of action for two months and they had reported this to the trust. Staff said they had not been informed of a date when the cots would be repaired or replaced.
- We saw tailgating signage on access points to ward areas reminding staff and visitors not to allow people they did not know into wards.
- Staff disposed of clinical waste safely. The hospital had facilities for the management of waste, including procedures for contaminated and hazardous waste, which staff adhered to. We saw noticeboards which displayed information for staff on colour coding for waste disposal bags.

Maternity

Assessing and responding to patient risk

Work was in progress to ensure staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

- During our previous inspection we found staff on triage did not use the modified early obstetric warning score (MEOWS). This is a way of formalising measurement of physiological variables. The values of the observations are then translated into a summary score which has a critical threshold, above which medical review and intervention is required. During this inspection we saw that the service had introduced the use of the modified early obstetric warning score (MEOWS) in triage.
- During our inspection we looked at 15 MEOWS records and found these to be complete and correct. Maternity services audited MEOWS in October 2021 and recorded 93% compliance in the use of the tool.
- Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Gaps in risk assessments were a primary feature of perinatal reports about the service, such as Health and Safety Investigation Branch (HSIB), serious incident (SI) investigations and 'Mother and Babies: Reducing Risk Through Audit and Confidential Enquiries' (MBRRACE).
- The service had identified areas where improvements were required in individualised risk assessments and had developed a risk assessment tool in response.
- The risk assessment tool at booking was on the maternity services risk register. The risk register recorded that following the Ockenden report and learning from serious incidents, a new risk assessment tool for booking and follow-up appointments was devised and implemented in March 2021. Information on the use of the tool and requirements for completion during every antenatal contact were widely disseminated to staff, through newsletters and team meetings. The service also ensured all users of the tool had completed training in use of the tool. A progress review in July 2021 of 10 risk assessment documents found 100% compliance with women being allocated to the correct pathway. However, the review found 75% compliance with continuous risk assessments, this was a drop from May 2021 when the compliance rate was 84%. In response, the service decided that risk assessments would remain on the risk register. This demonstrated the service were aware of the risk regarding documented risk assessments and were taking action to monitor risks.
- The service had introduced the 'Saving Babies Lives, version two' care bundle. Staff training on use of the care bundle was on the service's risk register. The service had taken action to mitigate risks in the use of the care bundle, including: guidance and pathways for staff; growth scans for babies identified as measuring small or at risk of growth restriction; pre-term risk assessments; dissemination of information on reduced fetal movement for staff; introduction of a fetal surveillance midwife; weekly cardiotocography (CTG) meetings with shared learning for medical and midwifery staff; the appointment of a consultant lead for the labour ward and CTG; practice development midwives working Monday to Sunday; a dedicated consultant for the pre-term clinic, and the maternity improvement group monitoring the use of the care bundle.
- Staff knew about and dealt with any specific risk issues. The London Maternity Neonatal System (LMNS) is a partnership of organisations, women and families working together to deliver improvements in local maternity services. Northwick Park Hospital used the LMNS dashboard to monitor performance and to benchmark services with other providers in the LMNS.
- The LMNS dashboard recorded the rate of puerperal sepsis as 0.8% in the year to July 2021. This was better than the LMNS network baseline rate of 1.5%. Maternity services had audited the sepsis pathway in 2020, and as a result an action plan was implemented to monitor compliance with the puerperal sepsis pathway. A re-audit was scheduled for January 2022.

Maternity

- We reviewed minutes from the maternity unit meeting, dated 27 August 2021. The minutes recorded that new recruits in the neonatal unit (NNU) would be updated on the use of an early onset sepsis calculator.
- The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The service had regular planned psychosocial multidisciplinary meetings to discuss and review the psychosocial needs of women or babies at risk. The meetings facilitated immediate referrals to members of the multidisciplinary team and were a forum to provide feedback regarding interventions.
- Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. The service had twice daily multidisciplinary handovers. We attended the 8am multidisciplinary handover on 25 October 2021. The handover had 14 incoming staff in attendance and was led by a medical registrar. Attendees included the delivery suite manager, director of midwifery, anaesthetist, and neonatal consultant. The handover included a safety briefing for the incoming shift. The service discussed elective caesarean sections for the shift and identified three women that were scheduled for caesarean sections.
- The service audited the induction of labour in April 2021, this involved the review of 21 women that had their labour induced between March 2020 and February 2021. The audit confirmed that induction of labour occurred within 48 hours in 50% of the cases but identified delays in the remaining cases. The audit found this was attributable to the capacity in the antenatal unit and delivery suite at peak times.

Midwife staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

- During our previous inspection in April 2021, there was a high Band 6 vacancy rate and high use of bank and agency staff. During this inspection we found the service still did not always have enough nursing and midwifery staff to keep women and babies safe. As at August 2021, there was a 28.7% midwifery vacancy rate. All the staff and managers we spoke with identified midwifery staffing as the main challenge for the maternity service. However, most staff we spoke with identified that staffing was improving. The Ockenden Review published in December 2020 detailed a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each NHS trust's maternity services. NHS trusts were asked to undertake a maternity workforce gap analysis, and to have a plan in place to meet the Birthrate Plus standard for 1:1 care for women in labour by the 31st January 2021 and to confirm timescales for implementation. The service had completed a Birthrate Plus assessment in 2019. Based on the planned establishment the ratio was 1 midwife to 23 women, however due to the high number of midwifery vacancies at the time, the ratio was 1:28. However, managers told us that in September 2021 the actual ratio was 1:31. This was worse than the 1:23 Birthrate Plus assessment.
- The red, amber, green (RAG) rated LMNS dashboard in the year up to July 2021 was green rated at a ratio of 1:28 for direct clinical care. This was slightly worse than other trusts in the LMNS network. The green standard for the LMNS dashboard was 1:30 and the red was 1:33.
- At the time of inspection, managers told us there were 53 vacancies across maternity services, this included 40 vacancies at band 6. Data provided by the trust dated September 2021 recorded that the established midwifery whole time equivalent was 229.64. The actual rate in September 2021 was 161.4 whole time equivalent staff. This meant the service had 68.24 midwifery vacancies (30%) in September 2021.

Maternity

- We viewed three sets of minutes from divisional governance meetings from July to August 2021. We found recruitment was discussed at every divisional governance meeting. Managers told us there were a number of staffing and workforce initiatives being implemented, but these were work in progress. This included the recruitment of return to practice midwives, the recruitment of general nurses, overseas recruitment, and a support package for newly qualified midwives.
- The service did not fall within the area for the London weighting allowance pay scale. Managers said this had acted as a disincentive to potential new recruits, as they could travel one station further on public transport and receive London weighting allowance. In response the trust had introduced the London weighting allowance pay scale as an incentive to recruit new staff.
- As part of the service's recruitment initiatives, the service was conducting scoping calls with band 2 and band 3 maternity support workers. This meant the service could assess the skills and attributes of potential candidates prior to the candidate making a formal application.
- Staff told us that due to staffing shortages some staff were the named midwives for multiple services. Staff said this meant the named midwives could not spend the required amount of time on the tasks expected of a named midwife.
- The number of midwives and healthcare assistants did not always match the planned numbers. During our inspection, wefound the delivery suite safer staffing dashboard recorded the established number of staff for the shift was 11, when the actual number on shift was recorded as nine. The shift also had four maternity care assistants. We also found the safer staffing dashboard displayed the incorrect name of the labour ward coordinator for the shift. Staff corrected this immediately when we drew it to their attention and put the correct coordinator's name on the dashboard.
- Staff told us the birth centre was closed on the night of 24 October 2021 and staff on the birth centre had been redeployed to the delivery suite to supplement staffing on the delivery suite.
- All the midwifery staff on the night shift were agency midwives. However, staff told us they were regular agency staff and worked regularly on the delivery suite, some had worked for the trust previously. Staff on the shift told us they were supported by a band 8 on-call manager. Staff said the shift had been a quiet shift and staffing cover had been adequate.
- The maternity day assessment unit established staffing level was four whole time equivalent (WTE) midwives. However, the actual staffing level was: one full time Band 5 midwife, who was on annual leave on the day of inspection; a Band 6 midwife who worked 15 hours a week, and one full-time WTE Band 7 midwife. Staff said they had been advised by managers that there was a plan in place to recruit a further 1.5 WTE midwives to staff the antenatal unit.
- Community midwives were all permanent or bank staff. Community midwifery did not use agency midwives.
- Managers could not adjust staffing levels daily according to the needs of women. For example, on the 25 October 2021 the maternity day assessment unit (DAU) established number of midwives was two, but there was only one midwife on shift. However, the unit was being supported by two student midwives.
- One member of staff told us the service was regularly short of scrub nurses in theatres. For example, on the 25 October 2021, between 6pm and 8pm, the established number of scrub nurses required was two. The actual number of scrub nurses on shift was one.
- Managers said the recruitment of midwives was a trust priority. Staff told us they were aware of the trust's recruitment initiatives. Work was in progress on recruiting midwives from overseas. Managers said this was to balance the workforce and reflect the trust's demographic.

Maternity

- The trust provided the inspection team with dashboards which they used for the monitoring of sickness rates and rates of bank and agency use. However, these had not been completed. Following the inspection, the trust submitted sickness rates for nursing and midwifery staff which was 8.3% as at October 2021.
- The new interim director of midwifery had reviewed agency and bank usage. They found that bank and agency usage correlated with the number of shifts the service needed to cover. The review found that there was no excess use of bank and agency staff. Data from the trust showed on 30 September 2021 maternity services establishment of qualified midwives Bands 5 to 7 was 151.87. The actual number in post was 106.68. Agency staff usage was 22.86, this was 15% of whole time equivalent (WTE) staff.
- All the bank midwives had worked for the trust in a substantive role prior to joining the bank. Agency midwives told us they were on open contracts and most had worked as agency for the trust for a number of years and were familiar with the service.
- Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff we spoke with told us they received the same induction as substantive staff.

Medical staffing

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

- The service had enough medical staff to keep women and babies safe. Obstetricians, paediatricians and anaesthetists were available 24 hours a day. Consultant presence was provided seven days a week for 12 hours a day; with a consultant available on call for the remainder of the time.
- Consultant cover for antenatal diabetic clinics was on the maternity risk register. This was due to a lack of consultant cover for the clinics. However, we were told during the inspection that two consultants with maternal medicine and diabetes experience had been recruited and were due to take up their posts in December 2021. To mitigate the risk there was a dedicated specialist diabetic midwifery team with expertise in diabetes. Junior doctors with a specialist interest in diabetes were running clinics. Diabetes consultants and nurses from the main hospital could be remotely consulted for advice.
- The consultant covering the elective caesarean section list also covered the DAU. Staff told us there was a junior doctor on the wards who would be contacted first, but consultant input was provided by the consultant on the caesarean section list.
- The service had three locum consultants at the time of inspection and had recruited another four locums who were taking up their posts between November 2021 and January 2022.
- The dashboards provided to us by the trust had areas for the monitoring of staff turnover, sickness rates and rates of locum use. However, these were not completed for September 2021. Following the inspection, the trust submitted sickness rates for medical staff which was 0% as at October 2021. Data from the trust showed there was a 8.5% vacancy rate for junior doctors, 13.3% for registrars and 25% vacancy rate for consultants which was being covered by six locum consultants.
- The trust sent us a medical staff chart, this recorded in September 2021. The service establishment for obstetrics and gynaecology consultants was 25.10 whole time equivalent. The actual number of consultants employed was 24.75, with 4.45 of these staff being bank staff. This meant substantive consultant staffing was 93% of its establishment.
- Medical staffing identified as ‘other’ in the same period establishment was 48.6 whole time equivalent. The actual number of medical staff ‘other’ was 46.91, with 5.09 of these staff being bank staff. This meant substantive medical ‘other’ was 75% of its establishment.

- Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a range of skill mixes of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.
- The red, amber, green (RAG) rated LMNS dashboard was rated as green, in the year to July 2021, for the obstetric unit providing seven day a week dedicated consultant presence for 12 hours per day.

Records

Staff kept records of women's care and treatment. There was a risk of triage log sheets becoming detached from women's notes and information on the sheets being misplaced. We found that 'Time alone' records were not always being recorded at every antenatal appointment.

- Staff on triage told us they entered calls from women in a call logbook. However, staff told us the logbooks had been withdrawn and they were using call log sheets. The trust informed us the service was planning to roll out the Birmingham Symptom Specific Obstetric Triage System (BSOTS). In the meantime, the service was using a triage log sheet which allowed an easier but more comprehensive assessment, until BSOTS was introduced and embedded. However, these were loose documents which meant there was a risk of these becoming detached from women's notes and information on the sheets being misplaced, as the information was not recorded on women's electronic patient records.
- The triage assessment had recently been updated to record the time women arrived at the service and the time they were seen. This meant the service would be able to audit and monitor the time women waited in triage before being seen by staff.
- The maternity service had a robust Situation-Background-Assessment-Recommendation (SBAR) tool to ensure appropriate risk assessment when women accessed the triage service. (SBAR is a technique which provides a framework for communication between members of the health care team about a patient's condition). However, staff on triage told us the tool was not being used and said they were not aware of any guidance on how they should use the tool. Triage staff said if a woman was moved more than once, staff in the department women had been transferred to would complete a new form.
- The service had completed an audit of the SBAR tool in October 2021. The audit found 87% were fully completed; 13%, or nine of 69 records reviewed, were not fully completed. In response, learning from the use of the tool had been disseminated to matrons. The service had scheduled a re-audit of the tool in July 2022, to ensure learning was embedded.
- The service had completed an audit of medical records in October 2021, records reviewed dated from June 2021 to October 2021. The audit found mental health risk assessments demonstrated high levels of completion. Records of the antenatal screening programme also had high levels of completion.
- Postnatal assessments were recorded on the trust's electronic record system and had a completion rate of 100%.
- Discharge summaries were sent to health visitors and GPs. The summaries included information about the women's pregnancy, labour and postnatal care, medications they had been prescribed, and any ongoing risks.
- Work was in progress to roll out a fully electronic patient records system in 2022. This was a records system widely used in the NHS and LMNS.

Medicines

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

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The maternity service used automated medicines cabinets to store, administer and reorder medicines. This ensured staff had 24-hour access to in date medicines. Staff were accountable for any medicines they used, as this was automatically reported to a central server. The automated system prevented unauthorised access to medicines and provided an audit trail, as well as reducing waste, stock and expiry risks.
- Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. We saw medicines being reviewed at a ward round.
- Staff stored and managed medicines and prescribing documents in line with trust policy. Medicines were stored in secure automated dispensing cabinets in a room allocated for the purpose of storage and dispensing of medicines. Access to the room was via a keycode, this prevented unauthorised access to the medicines room.
- Overall, staff followed current national practice to check women had the correct medicines. We found that maternity services followed best practice and had an automated controlled drug dispensing system. All the drugs we checked were in date. However, we also found the top draw of an open trolley on the delivery suite used for storing hats, contained two drugs vials. We drew this to staff attention, and they removed the vials immediately and placed them in secure storage. However, there was a risk of unauthorised people having access to the drugs on the trolley.

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 patients honest information and suitable support.

- During a previous inspection in April 2021 we found learning from incidents was not embedded and incidents were not escalated and graded appropriately in accordance with the services serious incident and reporting policy. During this inspection staff knew what incidents to report and how to report them. We saw guidance for staff on incidents displayed in the handover room. For example, a risk noticeboard had a ‘trigger list’ to guide staff on reporting incidents.
- Maternity services used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately. There was a process of review and monitoring for incidents. The maternity risk team ‘walked the floor’ daily to identify incidents and ensure they were reported. Incidents were reviewed locally within the maternity team and reviewed by the corporate patient safety team. Incidents were a regular agenda item at clinical governance meetings. Incidents were also reviewed as part of maternity risk update sessions. For example, we viewed a presentation from a risk update session dated 6 July 2021. During the session incident trends were analysed and actions to address risks identified. We also saw incidents being discussed during a morning handover.
- We reviewed data from the *National Reporting and Learning System* (*NRLS*), this is a central database of patient safety incident reports. In the period May to September 2021, there had been: 425 ‘no harm’ incidents; there had been 103 ‘low harm’ incidents; 58 ‘moderate’ incidents; two ‘severe’ incidents; and no deaths. We found most ‘moderate’ incidents related to 3rd and 4th degree tears. We also found some ‘no harm’ incidents relating to staffing shortages.
- In accordance with the Serious Incident Framework 2019, maternity services reported five serious incidents (SIs) in obstetrics, which met the reporting criteria set by NHS England, between May and September 2021. We viewed three root cause analysis (RCA) serious incident investigation reports. These documented actions the trust had taken in the investigation of serious incidents. The RCA reports also identified learning from incidents for staff.
- Staff told us incident reporting had been included on the inductions of both new junior doctors and new midwives to promote a culture of incident reporting. Staff told us the service was encouraging a ‘no blame’ culture in regards to the reporting of incidents.

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- Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us the service had focused efforts on incident reporting. This included allocating a midwife to assist with the review of incident reports. Managers told us as a result there had been a rise in the number of incidents staff were reporting.
- Never events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The service had one never event. The incident occurred in September 2021 on the delivery suite. The incident was in relation to a retained swab following an induction. The swab count was signed as correct by two signatories.
- We viewed the 72-hour report regarding the never event in September 2021. The 72-hour report identified issues as: suturing documentation not being completed, and maternal postnatal check documentation not fully completed. In response the service took immediate action and emailed all clinicians about the importance of completing and documenting swab and needle counts. A root cause analysis (RCA) investigation was in progress at the time of inspection.
- Managers shared learning about never events with their staff and across the trust. Managers also shared learning with their staff about never events that happened elsewhere. Staff told us they received regular safety bulletins and safety briefings from the risk team. The perinatal team told us they monitored information in the safety briefings. We saw safety information on swab counts displayed in the staff handover room.
- Staff reported serious incidents clearly and in line with trust policy. The London Maternity Neonatal System (LMNS) dashboard dated July 2021 recorded that the service had five serious incidents which met the serious incident (SI) criteria. Any incidents which met the criteria were subject to a 72-hour report, which was completed by the maternity multidisciplinary risk team. Incidents meeting the criteria were reviewed by the lead consultant obstetrician and lead risk midwife. The service had introduced weekly serious incident review meetings to enable learning from serious incidents to be shared across disciplines.
- Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. The duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support. Duty of candour was included in the induction training for new staff. Staff we spoke with told us they had received training in the duty of candour and were aware of their duty of candour responsibilities.
- The perinatal team had responsibility for the duty of candour. Duty of candour was a key performance indicator for the team. The team met with and submitted data monthly to the regional team to discuss the duty of candour.
- Staff received feedback from investigation of incidents, both internal and external to the service. Community midwives told us they always received feedback when they reported incidents. Maternity services had copies of the risk newsletter displayed on a noticeboard in the handover room on the delivery suite. We saw that learning from a never event was included in the risk newsletter in the form of an action plan. All staff received the risk newsletter monthly via email.
- Staff met to discuss the feedback and look at improvements to patient care. We viewed the maternity risk newsletter dated August/September 2021; this reviewed incident reporting trends as learning points for staff. We also saw that learning from incidents was on the agenda at twice daily safety briefings.
- Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We viewed a 72-hour report following a never event in September 2021. The report clearly documented that the woman involved had received verbal duty of candour and had been provided with information on how to contact the patient advice and liaison service (PALS).

Maternity

Is the service effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

- Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. During a previous inspection in April 2021 we found some of the service's clinical guidelines were out of date. During this inspection we reviewed a range of guidelines including antenatal care guideline; induction of labour guideline; and the vaginal birth after caesarean section (VBAC) guideline; recovery and enhanced maternal care guideline; and breast abscess guideline. We found all the guidelines we viewed were in date and had a date for review. The induction of labour guideline had been updated to signpost staff to refer to the VBAC guidelines in cases where women had a previous caesarean section.
- The service had an antenatal care guideline, which was reviewed on 5 August 2021. This gave guidance to staff on the management of antenatal care, including antenatal bookings, risk assessment, screening, referral and follow up care. The guideline contained a flow chart with the midwifery and obstetric pathways. It also had details on how staff could access interpreters, for women where English was not their first language. The guideline had instructions for staff on booking interpreters prior to appointments to ensure they were available to support women.
- The service had 'management of sepsis in maternity guideline', dated April 2021. This was in accordance with NICE guidelines NG51: Sepsis recognition, diagnosis and early management. Managers told us the sepsis pathway was embedded. We saw information on sepsis management was readily available across maternity services. For example, staff information boards carried information on sepsis.
- The service had information boards for staff, these included best practice guidance. For example, we saw guidance for staff on group B streptococcus (GBS), this is a bacterium most women carry during pregnancy and have healthy babies. But there is a small risk that GBS can pass to the baby during childbirth and can cause serious complications. We also saw risk update boards which updated staff on risks on the maternity risk register.
- We saw that staff at handover meetings routinely referred to the psychological and emotional needs of women, their relatives and carers. Maternity services worked in partnership with local perinatal mental health services including community midwifery, health visitors and GPs, improving access to psychological therapies (IAPT), and local social care services to offer specialist care for women with mental health needs. The service offered assessment and treatment to women experiencing mental health difficulties during pregnancy and within the first year after delivery.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

- Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women were offered a choice of menu options and dietary requirements were taken into consideration with food provision.
- A specialist breast feeding midwife supported women with feeding their babies. All women we spoke to said they had received support to breastfeed soon after birth, and this had continued the postnatal ward. Women we spoke with gave positive feedback about the care they received with breast feeding.
- The LMNS network dashboard recorded the breastfeeding initiation rate as 91%. This was slightly better than other LMNS trusts. The percentage of babies receiving maternal breastmilk at first feed was 89%, this was amber rated on the dashboard as it was slightly lower than the LMNS baseline rate of 90%. However, the rate was better than other LMNS trusts.
- The national neonatal audit programme (NNAP) showed babies receiving mother's milk (82%) was higher than the national average (58%). However, this was a decrease on the service's rate in 2018.
- The service monitored breast feeding initiation rates on the red, amber, green (RAG) rated maternity dashboard. The service's standard was 90%. The service met the standard from April to July 2021. There was a slight decrease in August to September 2021, when the rate was 89%.
- Patient information on breastfeeding support was available throughout the department. There was a breastfeeding room for women to use with a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available. However, during our inspection we found milk fridges on the delivery suite were not locked and this created a risk that expressed milk could be removed or tampered with. We drew this to staff attention and the fridges were subsequently locked. We also found milk in the medicines room fridge which was not clearly labelled.
- A woman that was post-operative caesarean section told us she had not been offered sips of water or an intravenous drip, she said she had been in the hospital all day and only received fluids following her procedure at 2.30am the following day.
- The service had a Baby Friendly action plan. (The Baby Friendly standards provide services with a roadmap for transforming care for all babies, their mothers and families. It is an accreditation programme that enables services to support families with feeding and help parents build a close and loving relationship with their baby). The action plan identified the staff member responsible for a particular action and date for completion.
- We saw records that women's vitamin D levels were tested at booking and vitamin D was prescribed based on the results. (Vitamin D deficiency is thought to be common among pregnant women, particularly during the winter months, and has been found to be associated with an increased risk of pre-eclampsia, gestational diabetes mellitus, preterm birth, and other tissue-specific conditions).

Pain relief

Staff assessed and monitored women regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff prescribed, administered and recorded pain relief accurately. Most women we spoke with told us they received pain relief soon after requesting it. Women had access to a range of pain relief methods following NICE guidance CG190. This included gas and air and a morphine-based injection for medical pain relief during labour. However, one woman we spoke with told us their pain relief was delayed on the delivery suite for over an hour after requesting it.
- The LMNS dashboard recorded the number of regional analgesia in labour (combined spinal epidural or epidural, excluding caesarean sections) was 268 in the year to July 2021.

Maternity

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

- The service participated in relevant national clinical audits. The service had acted on the perinatal report published by Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) in 2020. The report highlighted limited parental engagement. In response the perinatal morbidity review team (PMRT) developed a standard operating procedure for parent engagement (SOP). This SOP outlined the expected practice in communicating and involving parents in reviews.
- The service had named medical and midwifery audit leads. The service had recruited a new audit midwife. The audit midwife said junior doctors were enthusiastic about audit and some of the scheduled audits had been allocated to the junior doctors. Audits in progress at the time of inspection included an audit of agency midwives to ensure they had access to the tools needed to do their jobs and a mattress audit.
- Community midwives told us they were emailed outcomes of audits in safety bulletins.
- Maternity services used the London Maternity Neonatal System (LMNS) dashboard to benchmark their performance with other services. The dashboard enabled the service to benchmarked itself against other NHS maternity units in North West London.
- Most outcomes for women were positive, consistent and met expectations, such as national standards. The red, amber, green (RAG) rated maternity services dashboard recorded between April 2021 and September 2021, 100% of women had received 1:1 care in labour.
- We reviewed the results of an audit into jaundice in new-born babies under 28 days old, October 2021. The audit found 80% of neonatal jaundice was identified on day five or over, this did not correlate with the timing of postnatal face to face visits. Although the service were conducting further analysis into the audit, it was noted that the babies were exclusively breastfed, with half of babies having a weight loss of 9% or more at admission. The audit found that 46% of the babies readmitted were born in other trusts. In response the service had developed a recruitment plan for midwifery support workers to provide face to face breastfeeding support 24 hours after discharge; redesigned 'Baby Friendly' assessment forms, to ensure effective feeding prior to discharge; shared information from the audit in the service's risk letter; and discussed the audit at weekly staff learning sessions and divisional governance meetings. The risk had also been added to the maternity risk register to enable monitoring of the risk.
- The London Maternity Neonatal System (LMNS) dashboard, dated July 2021, was red, amber, green (RAG) rated. The dashboard indicated that there had been four still births in the year to July 2021. This was green rated on the dashboard. The crude stillbirth rate was 3.07, this was better than the 3.12 LMNS baseline rate and better than other trusts in the LMNS network.
- The LMNS dashboard recorded there had been zero neonatal deaths in the year up to July 2021. The dashboard also indicated that there had been one intrapartum brain injury in the same period.
- The babies born before arrival (BBA) rate was amber rated on the dashboard at 1%. This was the same as the lower LMNS threshold. (BBA is a birth that happens away from a hospital or birth centre setting, prior to the arrival of a midwife).
- The induction of labour rate, including premature rupture of membranes, was 32%. This was similar to other services in the LMNS network.
- The spontaneous unassisted vaginal birth rate for all maternities was 36%. This was significantly lower than one trust in the LMNS network and about the same as other trusts.

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- The rate of normal vaginal births including spontaneous and induced labour was green rated on the LMNS dashboard at 63%. This was above the 55% LMNS network recommended rate. However, normal vaginal deliveries were red rated on the trust's maternity services red, amber, green (RAG) rated maternity services dashboard. The trust's standard was 55% or above. Between April 2021 and September 2021, the 55% standard had been achieved in one month in the period, this was July 2021 (55.4%). All other months in the period were below the red RAG rated standard of 50%. In the same period, April 2021 to September 2021, the number of instrumental deliveries were green rated on the RAG rated dashboard. This meant the number of women receiving instrumental deliveries was below the service's 16% trust standard.
- The LMNS dashboard recorded instrumental deliveries, all maternities, as 13%. This was green rated on the RAG rated dashboard. This was lower than the 16.9% LMNS recommended rate. The rate for unsuccessful instrumental births was green RAG rated at 0.6%.
- Post-partum haemorrhage of >1500 ml was green rated on the maternity services dashboard in all months from April 2021 to September 2021. The highest rate in the period was 1.7% in September 2021. The lowest rate was 0.3% in May 2021.
- The rate of full dilatation lower segment caesarean section (LSCS) was RAG rated green at 3.1%. This was better than the 5.9% LMNS recommended rate and better than other trust in the LMNS.
- The total number of caesarean sections was 37%, this was red rated on the LMNS dashboard, indicating it was worse than the LMNS baseline rate of 33%. The rate of prelabour caesarean sections, elective, was 17.1%, this was amber rated on the dashboard. Caesarean section in labour, emergency, was red rated on the dashboard at 20.1%, this was worse than the LMNS baseline rate of 15%
- Emergency caesarean section rates (category 1-3) had been consistently above 20% since August 2020. This was mirrored by the elective rate rise in the same period. However, there was a rise in caesarean section rates across the North West London maternity system. The dashboard target rate was 16% for emergency caesarean section, this not been achieved for the previous 12 months. In September 2021, the emergency caesarean section rate was 23%. The indication for emergency caesarean section was predominantly fetal distress (CTG abnormalities) or failure to progress. The service informed us clinicians may have been more risk averse during this period due to infection prevention and control procedures as a result of the COVID-19 pandemic.
- The maternity services dashboard target rate for elective caesarean section was 13%. This had not been achieved for the previous 12 months. In September 2021 the elective rate was 17%. The service was in the process of a qualitative deep dive to identify factors that may have contributed to the rise in the caesarean section rate.
- Research has found that magnesium sulphate antenatally can reduce the numbers of babies born with cerebral palsy. The service's rate of women receiving magnesium sulphate antenatally was 100%.
- Women experiencing 3rd or 4th degree tears was amber rated on the LMNS dashboard at 4.6% in the year to July 2021. This was worse than other trusts in the LMNS network.
- The post-partum haemorrhage of ≥1500ml was green RAG rated on the LMNS dashboard at 1%.
- The pre-term birth rate was green RAG rated at 5.6%. This was below the LMNS standard rate of 6%.
- The service participated in the national neonatal audit programme (NNAP). We viewed results from the 2020 NNAP. The service met the expected outcomes in most areas. However, the audit also found: A higher proportion of babies, (20.5%), compared to the national average, (12.4%), had temperatures over 37.5 degrees Celsius: Babies born at less than 32 weeks gestational age and surviving up to 48 hours with necrotising enterocolitis (NEC), (this is a serious gastrointestinal problem), decreased from 15.6% in 2018 to 5.6%, this is similar to the national rate of 5.5%;

- NNAP found the average number of separation days of babies from mother, 34-36 weeks gestation, was worse than the service's performance in 2018 when the rate was 7.6 days; the rate had risen to 8.3 and was worse than the average national rate of 6.5. The service had an action plan to address the outcomes of the NNAP audit.
- Between April 2021 and September 2021 there had been no unexpected admissions to the neonatal unit (NNU). The maternity services dashboard recorded there were no cases of meconium aspiration between April 2021 and September 2021. (Meconium aspiration syndrome occurs when a new-born breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery).
- The service had no cases of hypoxic ischemic encephalopathy (HIE) between April 2021 and September 2021. (HIE is a type of new-born brain damage caused by oxygen deprivation and limited blood flow).
- Managers and staff used audit and patient outcome results to improve women's care. Following the services induction of labour audit, the scheduling of women requiring induction of labour was changed. The induction of labour pathway was also being supported by the integrated care system (ICS), (ICS are partnerships between organisations that meet health and care needs across an area and plan in a way that improves population health and reduces inequalities between different groups).
- The risk register recorded actions still to be implemented as: the recruitment of specialist breastfeeding midwives; reinstating face to face visits the day following discharge; women being required to attend children centres or the hospital for checks; and liaison with neighbouring trusts to ensure discharge summaries were identifying relevant risk factors relating to babies. The risk was due for review on 30 November 2021 and had an expected date of completion recorded as 31 December 2021.
- The service used the maternity dashboard to monitor maternal non-elective re-admissions up to 42 days after delivery. From August 2020 to August 2021, based on the total number of births of 4323, the maternal re-admission rate was 3.46%.
- The service identified that over the period of October 2020 to October 2021 the neonatal readmission rate from community to the neonatal unit was 0.4%. From October 2020 to October 2021, a total of 44 incidents were reported for babies that were readmitted to either the neonatal or postnatal ward, the readmission rate was 1.1%.
- During our previous inspection in April 2021 we found the service did not have a member of staff in post to oversee the completion of audits in the previous 12 months. During this inspection we found interim managers and staff had carried out a programme of repeat audits to check improvement over time. The service had also recently employed an audit midwife, and work was in progress on a comprehensive audit schedule for maternity services.
- Managers shared and made sure staff understood information from the audits. We saw a range of PowerPoint presentations the service had produced in response to audit outcomes. We also saw information from audits on staff information boards. Audit outcomes were also shared in risk newsletters which were emailed to all staff.
- Improvements were checked and monitored. The service had a maternity improvement plan tracker to monitor improvements in quality and safety over time.

Competent 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.

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The new interim director of midwifery was in the process of reviewing band 2 to 4 midwifery care assistant competencies. This

was due to new managers being unable to find evidence of competency assessments for these grades of staff. Managers said the midwifery care assistants had previously been given bandings without evidence of competency. The interim director of midwifery said work was in progress to competency assess all midwifery care assistants' competencies.

- Managers gave all new staff a full induction tailored to their role before they started work. Medical staff said the time spent on induction was protected time. This meant medical staff could concentrate on being introduced to the trust's services and their roles within it.
- New midwives told us they had received an induction and felt well supported by colleagues and managers.
- The service had recently recruited six preceptor midwives. The preceptors told us they received an induction and preceptorship logbook which provided information relating to the preceptorship programme, what was expected of them as a staff member, linked strategies, the training elements of the programme, and final sign off for both induction and preceptorship.
- The service had a schedule of 'skills and drills' simulation training, including baby abduction, water births and major obstetric haemorrhage (MOH).
- Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they received regular annual appraisals. Managers told us the appraisal rate had reduced during the COVID-19 pandemic, but this was being addressed.
- Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers said they needed to further embed a culture of learning and quality improvement. The service had introduced the advocating for education and quality improvement (A-EQUIP) model of midwifery supervision. The service had seven professional midwifery advocates (PMA) to support midwives in their clinical practice and advocate for women. The PMA provided restorative clinical supervision; advocacy; and supported the service's quality improvement activities, including education and leadership for midwives.
- The maternity service had four WTE practice development midwives (PDM) in post. The PDMs had a database of staff training. Staff and their line managers received an email reminder three months prior to training expiring. However, the PDM said it was not part of their role to monitor staff mandatory training, as this was monitored by the trust's learning and development team.
- The maternity service had an integrated care system (ICS) support plan for training doctors which included mentorship and coaching from the local maternity and neonatal network. This included the service's compliance with maternity alliance for structured training (MAST) in October 2021, which provided support with parity of training opportunities across the local network, utilising opportunities for multidisciplinary education and multidisciplinary simulation training.
- Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they received regular supervision. Junior doctors said the supervisions were useful and supervisors were approachable. One junior doctor told us the consultants were good role models.
- Most junior doctors told us they received teaching on Fridays, and this was protected time. However, one junior doctor told us teaching had moved online due to the COVID-19 pandemic and they sometimes found it difficult to attend teaching sessions due to work commitments.
- Junior doctors were positive about ward rounds and said they felt fully supported on the rounds.
- The clinical educators supported the learning and development needs of staff. Maternity had offered six preceptorships to student midwives. These midwives were two weeks into their preceptorships at the time of inspection. Student midwives we spoke with told us they felt well supported in their roles. Managers told us the

service would provide training to preceptors above that required by the Capital Midwife Programme framework. (The Capital Midwife Programme was developed in response to the growing need to apply London' solutions to the challenges faced by the London midwifery workforce, this included staff support and learning and development). Managers said as a result of the preceptorships the service had student midwives expressing an interest in joining the service once they were fully qualified.

- Practice development and risk midwives ran regular learning from incident sessions. We viewed four email invitations sent to staff. This meant staff had access to shared learning opportunities from incidents.
- Staff had access to 'Learning from' information, this was used to share learning across the service. For example, we saw a noticeboard in the handover room which had information on learning from the management of obstetric haemorrhage.
- The maternity service was in the process of transitioning the online e-learning competency assessment tool for fetal monitoring and maternity crisis management, with a cardiotocography (CTG) training simulator. Maternity had made the decision to change the competency assessments due to evidence of better perinatal outcomes with the new system. The training was being rolled out from October 2021. At the time of inspection 69% of midwifery staff and medical staff had completed the new training and the remaining staff were booked to complete the training by January 2021.
- We reviewed maternity unit meeting minutes dated 27 August 2021. These noted that audit result from the 'Keeping Mother and Baby Together' pathway found improvements were required in the recording of the skin to skin safety checklist and hypo-glycaemia pro-forma. The clinical director was rolling out further training on the use of the pathway to neonatal staff.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend. Community midwives told us they were invited to attend the risk meeting, but this sometimes clashed with their clinical commitments or they were working in the community and could not get remote access to the meeting. Community midwives said minutes from the risk meetings were always emailed to them following the meeting.
- Midwives told us there were monthly staff meetings and any policy updates and learning from incidents was shared at the meetings.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The trust was offering staff short secondments to enhance their skills and knowledge. Mangers told us that it could be difficult to offer staff secondment opportunities due to staffing shortages. The shorter secondments gave staff the opportunity to develop their skills and knowledge without taking long periods away from their substantive roles.
- The trust offered the same training opportunities to agency staff as they offered to permanent and bank staff. Managers told us the service had long-term agency midwives that had worked for the service for a number of years. Agency staff were required to complete the same mandatory training as substantive staff.
- Managers made sure staff received specialist training for their role. Medical staff were trained in the use of Practical Obstetric Multi-Professional Training (PROMPT), this covers the management of a range of obstetric emergency situations. Staff told us PROMPT had moved online due to the COVID-19 pandemic.
- The service's continuity of carer (CoC) model had been paused at the time of inspection due to staffing shortages, (CoC is a model of midwifery based on the underpinning philosophy of care being based upon the natural ability of women to experience birth with minimum intervention and giving women increased choice about their place of birth). Managers told us they had discussed this with a professional body responsible for midwives, and they had been understanding due to the service's staffing situation.

- The service had reviewed consultants job plans and had linked these to activity and the service needs.
- Managers identified poor staff performance promptly and supported staff to improve. The service had commissioned an external organisational development company to deliver a multi professional programme of training and support to the clinical leaders of the service to address behavioural and cultural issues in the staff groups.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Maternity services had a range of multidisciplinary meeting including maternity unit meetings, which involved midwives, doctors, nurses, administrative staff and senior managers from maternity and neonatology.
- There were twice daily multidisciplinary handovers. During our previous inspection in April 2021 we found induction of labour cases, staffing or bed capacity was not discussed at the meetings. During this inspection we found this had been addressed and the meeting included relevant information for staff. We attended a handover during our inspection and saw the meeting was attended by midwifery staff, doctors and senior managers.
- Staff told us the trust had identified key improvement areas. This included the perinatal midwife liaising regularly with the consultant leading perinatal mortality reviews. The perinatal team had moved into a shared office and held regular catch up meetings.
- Staff at the neonatal unit told us they always received handovers from the maternity team when babies where transferred to the unit. Staff said they could ask any questions of the maternity staff.
- Staff worked across health care disciplines and with other agencies when required to care for patients. The service was working with the London Maternity Neonatal System (LMNS). This included reviewing the opportunity for on-site presence of a multidisciplinary team to assist in delivering change. Colleagues from leadership teams at external maternity units in the LMNS had visited the service to support improvements.
- Maternity services were working with another NHS trust in the LMNS by sharing learning and data on perinatal mortality reviews.
- The service had a multiple births team that offered twice weekly twins' clinics. The team included a fetal medicine unit (FMU) midwife, midwifery assistant, and sonographers.
- The service had infant feeding specialist midwives that could support women with breast feeding. The service also had access to a dietician for support with women and babies with dietary needs. The perinatal morbidity review team (PMRT) had asked an independent external reviewer from the child death overview panel (CDOP) to be an external member at PMRT meetings.
- Staff referred women for mental health assessments when they showed signs of mental ill health or depression. The perinatal midwives could offer midwives support when working with women with mental health needs. The perinatal midwives could also offer direct support to women with mental health needs.

Seven-day services

Key services were available seven days a week to support timely care.

- Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on their care pathway.

- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.
- The maternity unit was open for emergency obstetric pathways 24 hours a day, seven days a week. This included women in need of emergency obstetric surgery where they had access to a senior obstetric team, including a consultant obstetrician. There was access to two obstetric theatres as well as the main theatre suite. The gynaecology rota provided additional senior level support if required.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

- Staff assessed each woman's health at booking and provided support for any individual needs to live a healthier lifestyle. The LMNS dashboard recorded 67% of all smokers were offered smoking cessation treatment at their first booking. This was worse than the LMNS 90% baseline rate and worse than other trusts in the LMNS network.
- The service had relevant information promoting healthy lifestyles and support on maternity wards and units. We saw information relating to smoking cessation in waiting areas and wards across maternity services, some leaflets were available in a range of languages. We also saw information which signposted women to the local authority stop smoking service where they could get confidential advice and free nicotine replacement products.
- We saw information boards across maternity services which gave women advice on healthy lifestyles and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

We saw examples of records where patients' mental health needs were recorded. Staff were aware of the trusts Mental Capacity Act (MCA) policy and how this could be accessed.

- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff obtaining consent and procedures being explained to patients. Staff we spoke with understood the importance of shared decision-making with patients.
- Staff clearly recorded consent in women's records we viewed. All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Northwick Park Hospital was a pilot site as part of the implementation of the NHS Long Term Plan. Maternity services were involved in an ICS collaboration that involved providing psychological therapy, maternity support and peer support to women with complex mental health needs relating to their experience of loss or trauma in maternity, neonatal and perinatal contexts.

Is the service caring?

Good 

We rated caring as good.

Maternity

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. The hospital had a bereavement suite and multi-faith prayer room. Bereaved parents could stay overnight in the hospital with their babies. Bereaved parents were provided with memory boxes and photographs.
- Women said staff treated them well and with kindness. A woman who had recently given birth told us the midwives were “very caring” and said all the staff providing care had “gone above and beyond” in providing care and treatment.
- The maternity voices partnership (MVP) told us overall the feedback they received on the care women received was good. However, there were some themes they had identified regarding the postnatal ward, (Florence ward), being busy at times and women not feeling cared for as a result. The MVP said women reported that staff could be abrupt in their communication when they were busy.
- Staff followed the trust’s policies to keep women’s care and treatment confidential. The MVP told us they had not had women raise any concerns regarding women’s privacy but highlighted how comments from staff could have an impact on women’s’ experiences of care.
- Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. For example, a woman on the postnatal ward told us they wore a hijab and staff had been “very good” in respecting them and providing privacy regarding this.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

- Staff gave women and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The bereavement midwife told us the trust’s chaplains could arrange multi-faith support, such as Imams for people of Muslim faith, at short notice. The trust’s bereavement midwife told us maternity services worked with a funeral director and sometimes helped bereaved families plan funeral services.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

- Staff made sure women and those close to them understood their care and treatment. Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. For example, the service had invested in translation software which could translate information into over 100 languages.
- Women and their families could give feedback on the service and their treatment and staff supported them to do this. A maternity support coordinator spoke to all patients daily about their care and produced a monthly feedback summary for the interim director of midwifery.
- Women gave positive feedback about the service. The friends and family test (FFT), (this is a questionnaire to help providers understand whether patients are happy with the service provided, or where improvements are needed, had been suspended due to the COVID-19 pandemic. The service had reintroduced the FFT in 2021. We viewed the

service's improvement tracker, this monitored improvements over time in maternity. FFT results demonstrated an increase in women expressing satisfaction with the service over time. For example, in May 2021, 84% of respondents were positive about their care; this had risen every month until August 2021 when the rate of positive responses was 100%. For the question, would you recommend the maternity unit at Northwick Park Hospital to a friend or relative, we found the rate had improved over time. For example, in July 2021 the rate was 29%; this had risen to 56% in September 2021. However, it should be noted that the FFT response rates were low.

- Managers told us the service had a maternity support coordinator, this was midwife who spoke to all patients prior to discharge to gain feedback on their care. Managers told us the maternity support coordinator captured women's views qualitatively, and this was more useful than the FFT. Staff told us as a result of the feedback the maternity support coordinator had gathered, they had been able to identify three areas of improvement: Attitudes and behaviour of staff; transitions from the delivery suite to the postnatal ward; and triage.

Is the service responsive?

Requires Improvement

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

Staffing shortages had an impact on the way the service planned and provided care to local people and the communities it served. The service worked with others in the wider system and local organisations to plan care.

- The service saw a number of women through the antenatal and postnatal periods of their pregnancy. However, staff said they had seen a reduction in the number of deliveries as a result of a proportion of women choosing to deliver their babies at neighbouring units. Staff said they thought this was due to recent adverse publicity, and this putting some women off having their babies at Northwick Park Hospital.
- Staff and the maternity voices partnership (MVP) told us antenatal classes had been reduced as a result of the logistics of providing classes during the COVID-19 pandemic and staff availability. This meant that women had not had access to information that would improve their health and wellbeing during pregnancy. We were told there had been discussions about providing videos and online classes, but these had not been implemented at the time of inspection.
- The Birth Rate Plus midwifery report, dated 31 March 2021, recorded in the year 2019/2020 there were a total of 4708 births at Northwick Park Hospital; 4207 of these were on the delivery suite and in obstetric theatres, 459 were in the birth centre, and 42 were at home.
- The London Maternity Neonatal System (LMNS) dashboard was red, amber, green (RAG) rated and dated July 2021. The dashboard recorded that from July 2020 to July 2021 the service had offered 1694 women (100%) a choice of birth settings and the number of women giving birth in the midwifery led birth unit was 1296.
- Intended home births were red on the RAG rated maternity services dashboard. This meant the service were not meeting the 1.5% standard in any months from April 2021 to September 2021. The highest number of actual home births was six in May 2021, with the lowest rate at zero in June 2021.
- The birth centre had two birthing rooms, two birthing pools and 11 postnatal beds. The delivery suite had 11 birthing rooms. At the time of inspection women were not always given the choice of water births. Staff told us this was due to staffing shortages on the birth centre.

Maternity

- The antenatal ward had 15 beds. Clinics were from 8.45am to 2.30pm. At the time of inspection, all on-site antenatal and breast-feeding classes had been cancelled due to the COVID-19 pandemic.
- Community midwifery hours were from 9am to 5pm. Managers told us the services recent improvement efforts had been concentrated on hospital-based staff. Managers said work was in progress for an improvement agenda for community midwifery. Managers said community midwives did not provide on-call services and this was one of the proposed changes in community midwifery, as well as more flexible hours. However, community midwives we spoke with told us there was an on-call rota for community midwifery. Community midwives told us they did not always feel fully included in the maternity change agenda. Home birth services were available for women who lived in the local area. However, staff said there was low demand for home birth.
- Managers told us the service served a diverse population, and maternity services needed to be tailored to the needs of the local population. Managers and staff told us the COVID-19 pandemic had an impact on maternity services and the way they were delivered, as well as on women using the service. Changes the service had to make, in response to the pandemic, meant women had to attend appointments without the support of their loved ones for a period. Maternity services had changed the layout of the unit to allow clinics to continue whilst maintaining social distancing, and community midwives had to change the way they delivered care to women outside the hospital. At the time of inspection women could attend antenatal appointments with their loved ones.
- Managers told us the service had reviewed the service's layout, due to COVID-19 restrictions. Work to upgrade the postnatal ward had been completed. Managers told us they had an agreed capital budget, and part of the budgetary plan was improvements to the flow on the ground floor, which housed the antenatal unit, triage and delivery suite. However, this work was not in progress at the time of inspection.
- The maternity day assessment unit (DAU) was housed in a small area on the ground floor. The DAU had been moved from the sixth floor. The unit was comprised of two small rooms. The rooms did not have windows or ventilation. The unit operated from 8am to 8.30pm. Staff said the unit saw up to 30 women a day. The DAU had consultant cover from 9am to 5pm. Staff said the space was cramped and that the area did not have toilet facilities.
- The DAU shared a waiting area with the antenatal clinics. Staff told us the trust did not audit waiting times for women waiting in the antenatal and DAU waiting area.
- Staff told us there were issues with the fetal medicine unit (FMU) as it was co-located with the antenatal unit. Staff told us women receiving terminations of pregnancy frequently waited 45 minutes for their appointment, in the same waiting area as women attending antenatal and postnatal clinics. Staff said this could be distressing for women.
- The service had a level 2 neonatal unit, this had eight intensive care and high dependency cots.
- The trust had invested in a new transitional care unit, (transitional care is 'in between care' for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward) and a new antenatal department.
- Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. Maternity services were a pilot site for Maternal Mental Health Service (MMHS). The MMHS was an innovative joint programme between North West London NHS mental health and maternity services. Staff also told us the community perinatal mental health team were responsive.

Meeting people's individual needs

The service took account of women's individual needs and preferences. The service had made improvements to help women access services. They coordinated care with other services and providers.

Maternity

- Managers told us work was in progress to establish the fundamentals of safe care for women. This was in response to a report on eight perinatal deaths. In response managers had worked with the Healthcare Safety Investigation Branch (HSIB). The service had recruited perinatal and trauma midwives. Managers told us they were assured that risks relating to the report had been addressed.
- The service had information leaflets available in languages spoken by the women and local community. In response Healthcare Safety and Investigation Branch (HSIB) concerns and the Mother and Babies Reducing Risk Through Audit and Confidential Enquiries (MBRRACE) annual report 2020, the service had taken measures to ensure that interpreting services were accessible to staff and patients in all clinical areas.
- Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service had access to British Sign Language (BSL) interpreters from an external provider. Staff could access a full range of services for women with sensory loss, this included speech to text services and lip reading.
- The perinatal midwife had developed a perinatal pathway and work was in progress on developing a perinatal mortality review tool (PMRT). Staff told us they were looking at trends in the relationship between perinatal deaths and ethnicity. Staff said the work had identified increased risks between 32 and 36 weeks of pregnancy and this was the period of gestation the service were focusing on.
- The LMNS dashboard recorded that in the previous 12 months 100% of women had been offered a personal care plan. 55% of these women had a personalised care plan and this was slightly above the LMNS recommended baseline rate of 50%. However, this was the second lowest rate of the five trusts in the LMNS network.
- Staff made sure women living with mental health needs and learning disabilities received the necessary care to meet all their needs.
- Maternity services had a specialist mental health midwifery team. Staff could liaise with the team when providing care for women with mental health needs. Women could also have midwifery provision from a member of the mental health team. The team worked closely with the community perinatal mental health team, who could provide more specialist input and care.
- Access to interpreting and translations services was monitored by the service's maternity improvement group.
- Staff had access to communication aids to help women become partners in their care and treatment. The service had introduced an interpreting and translations software product. Staff demonstrated how they could translate information into over 100 languages, including Gujarati, Romanian and Farsi, by using the trust's software. Staff told us accessing any information on the trust's intranet in other languages was simple by using the translate software.
- All labour rooms on the delivery suite had been fitted with handheld telephones. Staff said they could call a telephone interpreting service and women in the labour room could speak directly with an interpreter. Women also had access to face to face interpreting services. However, these needed to be booked in advance. Managers said they were also looking at services that could provide face to face interpreters on request.
- All wards and departments had video screens. The video screens displayed information in a range of languages.
- Managers told us the service were focusing staffing improvement efforts on employing staff from the local area. The service was also planning an initiative to recruit overseas midwives that spoke the most frequently used languages in the locality.
- Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff told us the trust had prioritised improving access to interpreting and signing services. This included women at risk of domestic abuse that did not have English as a first language always having face to face interpreters booked.

- Community midwives told us they could book interpreters or signers as required. Community midwives said they found face to face interpreters were readily available.
- There were pathways of care for patients with learning disabilities. Women with learning disabilities or autistic spectrum disorder were identified at the booking stage and offered advice and extra support if needed. Women could be referred to the learning disability liaison officer. This was a specialist member of staff that could liaise with women and family members regarding women's' needs.
- Women were given a choice of food and drink to meet their cultural and religious preferences. There were a range of menus to suit women's' tastes and needs, including: religious and cultural menus, a vegan menu, and allergy aware menu.

Access and flow

People could not always access services when they needed it and receive the right care promptly.

- During the inspection we noted the birth centre was closed. Staff told us the birth centre was closed due to staffing shortages. Birth centre staff were redeployed to support the delivery suite.
- The Birthrate Plus assessment 2019/2020 found annually: 585 antenatal cases were seen on the delivery suite as the women required one to one care and for ongoing observation and monitoring. The birth centre provided intrapartum care to 459 women including postnatal care and new-born and infant physical examination screening (NIPE). There were a further 175 women who started their intrapartum episode in the midwifery led unit (MLU) but required transfer and completed their intrapartum episode on the delivery suite.
- The red, amber, green (RAG) rated maternity dashboard for the number of women delivered was red rated from April to September 2021. This meant the service's standard of 442 per month was not met in any of these months.
- The Day Assessment Unit operated a seven day a week service from 9am to 5pm. Triage was open 24 hours a day, seven days a week. Community midwives' hours of operation were from 9am to 4pm.
- The maternity unit was open for emergency obstetric pathways 24 hours a day, seven days a week. This included women who required emergency obstetric surgery. Women had access to a senior obstetric team which included a consultant obstetrician. A separate gynaecology rota provided additional senior level back up when necessary. There was access to two obstetric theatres and the main theatre suite. We saw guidance on the COVID-19 delivery pathway for women receiving caesarean sections displayed on the delivery suite.
- Staff on the antenatal unit told us things were improving when booking women's' antenatal appointments. Staff said there had been issues in the past with women having appointments booked when the consultant was not working. Staff said they had raised this with managers and the rota coordinator, and this had been resolved.
- The LMNS dashboard recorded 80% of bookings were completed by week 10 of pregnancy, in the year to July 2021. This was better than the dashboard standard of 60%. However, women booked at 10 weeks plus six days at 85% was slightly worse than the LMNS dashboard standard of 90%.
- The trust had undertaken a review of the antenatal care pathway focusing on the administrative systems and processes supporting the high-risk pathway. This involved a review dating back 40 weeks to ensure all women were captured and all follow up appointments confirmed. The maternity service was also carrying out daily reviews of electronic care plans to ensure follow up appointments were confirmed. Antenatal care provision was on the agenda for discussion at the maternity clinical governance meeting in November 2021 with a view to adding the antenatal care pathway to the maternity risk register to ensure the pathway was monitored.

Maternity

- The red, amber, green (RAG) rated trust's maternity dashboard recorded antenatal bookings (excluding late referrals), as green in all months April 2021 to August 2021, this meant the service's 95% standard had been met. The standard was amber rated in September 2021, when the rate was 94.5%.
- The percentage of women delivered in the birth centre was red rated on the maternity dashboard in all months April 2021 to September 2021. This meant the service's 18% standard had not been met in any month. The highest rate in the period was 12.6% in May 2021 and the lowest rate was 8.9% in September 2021.
- Maternity triage had a flowchart displayed on the unit. This outlined women's journey from check in, assessment to treatment.
- Staff told us the triage policy was to admit women on their third call in 24 hours to explore any concerns. However, there was no system of recording the time at which women with concerns had called.
- We looked at data the service had collated in a triage audit. We found between 8 July 2021 and 6 August 2021, 17 of 71 women triaged were delayed due to staffing capacity: From 1 September 2021 to 21 October 2021, 13 of 108 women triaged were delayed due to staffing capacity.
- Managers told us there were plans to move the triage to the pre-delivery suite, in November 2021, as it would improve the flow of women using the service. An external provider of IT services confirmed that they were reviewing the triage pathway with managers, with the intention of streamlining the triage process.
- Medical staff on the DAU told us there was no clear policy on women who should go to triage and women that should go to DAU. This meant there was no clear assessment pathway for pregnant women who attended hospital with pregnancy related complications or concerns.
- During a previous inspection in April 2021, we had an allegation of poor induction pathway for women. During this inspection we found women attending the service for an induced birth arrived between 3pm and 5pm. The service had audited the induction pathway in April 2021. This identified two areas of concern, these were: a delay in commencing induction of labour: and transferring women to the labour ward. In response staff on the unit recommended changing the time of admission. Subsequent analysis from August 2021 noted that 89% women had induction of labour within two hours of arrival, this was an improvement from the audit in April 2021. The audit also found 82% of women were transferred within 12 hours of informing the labour ward. The service acknowledged that the delay in transfer required further improvement and was being monitored via audits and a daily log. The service had a re-audit of the induction pathway scheduled for December 2021. The service also intended to re-audit the pathway at regular six-monthly intervals.
- As a result of the induction pathway audit the service had added to the induction booklet a record of the time women arrived for their induction of labour. Staff told us as a result they were better able to monitor how long women had waited for their induction. The service had produced an induction pathway flowchart that gave staff a clear visual guide to the flow of women through the pathway.
- There was also a quality initiative in progress to look at improvements to the induction pathway. For example, a 'task and finish' group were in the process of setting up a new electronic induction pathway.
- The service was receiving support for maternal medicine diabetic services and fetal medicine in the form of mutual aid from other trust's in the integrated care system (ICS) with the aim of reducing waiting times on the admitted lists. The trust's theatre teams also helped with full pathway patients and weekend theatre lists.
- Managers told us waiting times for women across maternity services reflected staffing levels. Staff told us they were being encouraged to report delays as incidents.

Maternity

- The service used a tracker to monitor improvements over time. We found a sharp increase in delayed induction of labour in August 2021. The rate had risen from 2% in July 2021 to 33% in August 2021, the rate in September 2021 was 6%. The tracker recorded that staffing shortages had contributed to the high rate in August 2021.
- The service performed an average of three caesarean sections a day. Managers told us 40% of these were emergency caesarean sections. Work was in progress at the time of inspection to review the midwifery led pathway for caesarean sections.
- Staff told us there were no issues with capacity on the neonatal unit. However, there was a limited outreach service. The service had one part-time outreach nurse. Staff told us there were currently no plans to expand the service but thought service expansion would enable earlier discharge of low-weight babies and babies on oxygen therapy.
- Community midwives told us staff shortages had an impact on the ability of the service to provide clinics and home visits. Staff said clinics were sometimes cancelled and home visits were sometimes rearranged in the diary due to staffing shortages. However, managers said they were reviewing the model of community midwifery, as services should "wrap around" the women using the service. This included a review of the hours of midwifery cover in community services.
- Managers told us they had asked the trust's operations team to look at maternity demand and capacity, this was work in progress at the time of inspection.
- The LMNS dashboard recorded that in the year to July 2021 there had been no closures of the maternity unit at Northwick Park Hospital.
- The LMNS dashboard recorded two planned home births and 12 actual homebirths. This equated to 0.9% using National Health Service England (NHSE) measurement. This was slightly less than the LMNS recommended rate of 1%.
- The service had neonatal screening and referral pathways in place, this included a mechanism that meant that babies not screened within 72 hours of birth would be identified. However, staff said the new-born and infant physical examination (NIPE) clinics for low risk babies were occasionally not facilitated due to staffing shortages.
- The national neonatal audit programme, 2020, found: the proportion of parents who had a consultation with a senior member of staff within 24 hours was 98.9%, this was higher than the national rate but slightly lower than the service's 2018 data (99.1%).
- The LMNS dashboard recorded intrapartum transfer to the labour ward for women labouring on the midwifery led unit as 24% in the year to July 2021. The dashboard recorded intrapartum transfers to the labour ward from home, (labouring at home and intending on a homebirth), as 0%.
- Intrapartum transfers to the delivery suite from the birth centre and midwifery led unit (MLU) was green RAG rated on the maternity services dashboard in all months from May 2021 to September 2021. The service's standard was less than 26%, the highest rate was 25% in July 2021 and the lowest rate was 6.5% in September 2021.
- The LMNS dashboard recorded there had been no maternal admissions to the intensive therapy unit (ITU) in the year to July 2021. The maternal mortality rate in the same period was zero.
- Most women receiving postnatal care were from other NHS trust hospitals. Managers told us work was in progress to improve planning for postnatal care. Maternity managers had engaged with both midwifery and medical staff with the improvement planning. The plan was scheduled to be launched on 18 November 2021.
- There was guidance for staff on transfers to the neonatal unit, 'NNU admission criteria V2' and 'Neonatal transfer to MRI'. Neonates requiring transfer to other hospitals were transferred using a specialist neonatal transfer service.

- Managers and staff worked to make sure that they started discharge planning as early as possible. Staff told us discharge planning started on admission. Women being discharged received information outlining medication needs, follow up, and contraception methods. Before departure advice was given on cot death risks including smoking and sleeping positions for their baby.
- Women with mental health needs discharge planning started at 32 weeks. The perinatal mental health team (PMHT) facilitated multi-agency pre-birth meetings to confirm discharge planning.
- The service was in the process of updating the patient electronic record to ensure it captured antenatal information on the postnatal discharge summary. This was scheduled for completion in March 2022.
- Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Women at risk due to domestic abuse, mental health or safeguarding concerns were flagged on the trust's electronic records system. This was a prompt that informed staff to look at the woman's risk assessment. Women received a discharge planning meeting. Staff told us they would not discharge a woman at risk without having planned the discharge and addressed the identified risks.
- Staff supported women and babies when they were referred or transferred between services. Women and babies were discharged from maternity, prior to being transferred to transitional care.
- Managers monitored transfers and followed national standards. We viewed the maternity risk newsletter dated August/September 2021. The newsletter identified jaundice and weight loss as the main causes of readmission. The newsletter had an action plan which detailed actions the service was taking in response, including improving communication between NHS trusts in relation to discharge summaries to identify high risk babies. This was an amber rated risk on the service's risk register. The risk was reviewed on 11 October 2021 and actions to mitigate the risk identified.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

- Women, relatives and carers knew how to complain or raise concerns. The maternity support coordinator undertook daily visits to the ward to identify and respond to areas of concern. The findings from these visits were escalated by the coordinator to matrons daily.
- The service clearly displayed information about how to raise a concern in patient areas. For example, we saw complaints leaflets in patient information racks across the service.
- Staff understood the policy on complaints and knew how to handle them. Staff told us concerns identified from feedback to the maternity support coordinator were dealt with immediately where possible. If women wished to escalate their complaints or concerns, they were provided with the contact details of the patient advice and liaison service (PALS).
- We saw patient information boards which gave details on how to make a complaint to the trust.
- Managers investigated complaints and identified themes. The LMNS dashboard recorded there was an average of six formal complaints per month in the year to July 2021. Complaints were reviewed at monthly divisional governance meetings and analysed for trends. We reviewed the minutes for the August 2021 divisional governance meeting. We found maternity had one complaint in the month, this related to staff attitude.
- The maternity improvement plan identified complaints responses and responses within agreed timescales as an improvement initiative. The improvement plan dated August 2021 recorded that the identified actions had been met.

Maternity

Is the service well-led?

Requires Improvement 

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

Leadership

Interim 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 patients and staff. The trust needed time to embed this improved leadership and also to forge a period of stability by making permanent appointments to the leadership team. Leaders of the service needed more time to embed the early signs of improvement and initiatives noted.

- The trust had introduced triumvirate teams at directorate, divisional and service levels. Maternity services sat in the trust's women's and children's division. At the time of inspection, the service had a substantive divisional clinical director and interim divisional general manager. The interim divisional general manager was contracted until March 2022. There was a new interim director of midwifery that had been in post for two months at the time of inspection.
- The service had safety champions from ward to board. The chief nurse was the executive board maternity safety champion and the trust also had a non-executive director who was a maternity patient safety champion.
- Senior managers told us the trust board was engaged with the maternity improvement programme. A senior manager told us the trust board were now aware of the challenges in maternity services and recognised that improvements in maternity must be a priority. Senior managers said the board were committed to supporting sustainable improvements. Senior managers met regularly with the maternity improvement group.
- At our last inspection there were mixed views from staff regarding support from the senior leadership. During this inspection, staff we spoke with were positive about the changes in leadership in maternity. A midwife told us they had previously left the trust and had gone to work for another provider. The midwife said this was due to issues with the management of Northwick Park Hospital maternity services. The midwife said they had seen positive changes in the managerial approach since they returned to work for the trust, with the biggest change being the visibility of senior managers.
- Some staff we spoke with said maternity services needed a period of management stability. All the staff we spoke with told us the new interim director of midwifery was approachable. A senior midwife told us, "Before it felt like them and us." This was echoed by other staff we spoke with, who told us it was a change to see senior managers being visible, wearing uniforms and working on the wards. One midwife told us they were "Impressed" by the change in the leadership approach.
- The service did not have a head of midwifery (HOM) at the time of inspection. The HOM role focuses on the operational delivery of maternity care locally. This is different from the director of midwifery, who leads and advocates for the strategic and operational delivery of maternity services locally. Senior managers said work was in progress on recruiting a HOM, but the service would not fill the vacancy until they found the right candidate. Senior managers said the service wanted to ensure they recruited the right people with the right skills in key roles.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, work was in progress on a vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy.

Maternity

- Managers told us a new vision for maternity services was in development at the time of inspection. Managers said they were engaging with staff on the vision for maternity, as they wanted staff to feel included and part of the vision. Managers were also engaging with the Maternity Voices Partnership (MVP), as managers said they wanted the vision to reflect local people's priorities.
- Maternity services had introduced a maternity improvement plan in February 2021. The plan was reviewed weekly at the maternity steering group. Some midwives told us they sometimes struggled to keep up with the rapidity of change in the service.

Culture

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

- A manager told us historically there had been tensions between a few of the medical staff and midwives. At our last inspection in April 2021 some staff had raised concerns about a blame culture within the service. At this inspection, all the staff we spoke with told us there had been improvements in the culture of maternity services. Although, some staff acknowledged that it would take time for the improvements to become embedded. Staff said the trust had introduced a zero-tolerance policy regarding bullying and inappropriate behaviour from staff. Managers said accountability was on the agenda regarding staff behaviour.
- Staff told us the culture of the service had been highlighted at staff engagement meetings. Most staff we spoke with told us they felt able to escalate inappropriate behaviour from their colleagues without fear of retribution. Staff told us the service was encouraging positive behaviours. For example, the trust had a 'civility' programme to encourage appropriate behaviour towards colleagues. The service had introduced 'back to the floor' days for managers, to address issues relating to the culture in maternity. The service had also introduced 'mindfulness' sessions to provide staff with the opportunity to focus on their wellbeing.
- Midwives were attending consultant meetings to improve relationships between the medical and midwifery staff. Senior managers told us there had been improvements in medical staff engagement. For example, all the medical staff had attended an engagement meeting in October 2021. Midwifery and medical staff had also been engaged in 'task and finish' groups.
- The service had a 'people plan' which was awaiting ratification at the November 2021 divisional management group. This was based on the NHS 'people plan', which included wellbeing support for staff, tackling discrimination, making effective use of staff skills and experience, recruitment and retention of staff.
- 'Freedom to speak up' is an initiative encouraging a positive culture where people feel they can speak up and their voices will be heard. The service had increased the number of 'Freedom to speak up' champions to six staff, these included both midwifery and medical staff.
- The leadership team had fortnightly staff engagement and briefing events co-ordinated by the leadership team. There were also twice weekly executive walk rounds, which were shared by the members of the executive team.
- Cultural issues were on the service's risk register. The service had engaged with the trust's human resources (HR) team to address issues concerning the culture of maternity services. Maternity services had recently appointed two staff members as culture representatives. Managers told us this was to address issues of trust between midwifery and medical staff.
- Managers told us staff retention was a priority. The trust had offered band 2 to band 7 midwifery staff a salary uplift as part of a staff retention initiative.

- The new management team had conducted staff listening events. Managers told us they had found these events useful in terms of hearing staff feedback and concerns.

Governance

Governance processes needed to be overhauled and time would be needed to embed the changes.

- New managers told us the governance structure of maternity was a challenge. The governance structure was being reviewed at the time of inspection. Managers told us the service was determined to put a governance structure in place that was focused on quality and safety.
- We viewed a flow chart which clearly demonstrated the flow of maternity information from maternity services to the trust board. This demonstrated the processes the trust had in place to ensure the board and senior managers were sighted on the maternity improvement plan. This included fortnightly meetings of the trust executive group, monthly maternity improvement group meetings, as well as board quality and safety sub-committee and trust board meetings.
- The maternity improvement group was the formal governance process for the service. The group was chaired by the chief executive officer and membership included the chief nurse, non-executive director and chief medical officer. The meeting had oversight of maternity audits. Managers told us the group was wide ranging and included a nurse consultant, ultra-sonographer superintendent, as well as staff contributors. Managers said the group was more relaxed than formal board meetings, due to be a working group focused on improvement in maternity services.
- There was a weekly maternity steering group, this was chaired by the executive maternity safety champion. The meetings were not recorded in minutes, as the focus of the group was the action plan, and any actions identified by the group would be recorded on the action plan.
- There were monthly clinical governance meetings which all eligible staff were required to attend.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

- The maternity improvement plan was a 'live' document and updated weekly. The plan was formulated in response to external reviews of the service. In August 2020 the trust noticed a rise in perinatal mortality. The Integrated Care System (ICS) supported an external review. All 28 recommendations from the review were included in the maternity improvement plan.
- Recommendations from the last CQC inspection in April 2021 were also used to inform the maternity improvement plan. The trust's Ockenden self-assessment and recommendations from the Health Service Investigation Branch (HSIB) reports, as well as feedback from the 2020 staff survey, staff engagement events and task and finish groups were integrated into the improvement plan.
- Managers monitored the improvement plan by using a tracking spreadsheet. Managers said they were aware that some actions identified on the plan needed to be sustained and further embedded. However, managers told us there was a different approach in the management culture and a determination to create an infrastructure that was fit for purpose, including governance and human resources (HR).
- The service had dedicated leads to drive the improvement agenda. For example, the service had recently recruited both an audit midwife and a risk midwife. The audit midwife had been in role for two months and the risk midwife was on induction at the time of inspection.

Maternity

- The risk register was reviewed at the division's monthly governance meeting and high rated risks were reviewed at the trust's risk and compliance meeting. Maternity was a risk on the board assurance framework (BAF) risk register, this was reviewed at meetings of the trust board.
- The maternity risk register was managed divisionally. The perinatal team also had oversight of the risk register. Any risk for inclusion on the risk register had to be submitted to the trust board.
- We reviewed the maternity services risk register and found it contained 16 risks. The risk register was red, amber, green (RAG) rated. There was one red risk on the register, this related to midwifery staffing. The risk register identified actions in place to mitigate staffing risks, but, recognised that there were still gaps. Actions required included a plan to recruit additional staff, redeployment of specialist midwives to clinical areas, upskilling of maternity assistants, escalation to the executive team regarding condensing services or capping bookings, remodelling of maternity service provision to align community midwives working hours with the service.
- The risk register was reviewed on 2 November 2021 this review recorded the trust was offering band 5 salaries to preceptorship midwives, as well as a training package for band 7 midwives including a study day and competency book. The risk register also recorded there was on-going review of the continuity of care and potentially condensing services, including consideration of five-day services for the day assessment unit.
- The service had an audit plan in place. The service was also planning to introduce an audit tracker, to monitor whether care was being provided in accordance with best practice standards and identify where there could be improvements.
- The service used the maternity dashboard to monitor performance. Senior leaders told us the dashboard had been in use since 2006. However, we found a manager on the delivery suite who said they were not aware there was a performance monitoring dashboard.
- During a previous inspection in April 2021 we found the maternity service's high priority risks were not shared with all staff. During this inspection we found the service had introduced a monthly risk newsletter to highlight and inform staff on risks to the service or women using the service. This was regularly sent to all maternity staff by email. We viewed a newsletter for August/September 2021 and found this disseminated learning from a never event. We also saw risks from the risk register on staff information boards.
- The service had introduced two 'transformation leads' to lead on the 'Maternity Transformation Programme'. The trust had declared compliance with five of the 10 maternity workstreams in the Clinical Negligence Scheme for Trusts (CNST). Managers told us the staffing situation meant they could not declare compliance with all CNST criteria.
- The service had four safety champions. The safety champions reported to the chief nurse, who was the board level safety champion.
- There were joint monthly mortality reviews with senior medical staff and midwifery. The service had regular mortality and morbidity meetings. The medical mortality lead had completed a draft study into mortality documentation and had presented the findings at the maternity improvement group.
- There was regular perinatal mortality review team (PMRT) meetings. We looked at three PMRT meeting agendas and minutes. Post-mortem reports were reviewed at the meetings. The meetings included a grading of the care provision and identified any lessons that could be learnt from perinatal deaths.
- Senior managers highlighted that the service had made significant improvements in a short space of time. But, acknowledged it was an improvement journey and it would take time to embed the changes. The priorities for the

service were: midwifery staff recruitment and retention; recruiting a permanent director of midwifery; delivery of the organisational plan, including improvements in the service's culture; coordination of efforts with the London Maternity Neonatal System (LMNS) support team and national maternity safety team; and delivery of the maternity improvement 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 had a digital improvement programme. Managers told us maternity services were still paper based and digital improvement was a key part of the maternity strategy. Managers were working with IT to improve electronic records systems with the aim of becoming paper light. The service's intention was to move in stages to achieve full digitisation in 2022.
- Staff told us IT access had improved. For example, staff on the fetal medicines unit (FMU) told us they had issues with internet connectivity. However, this was raised with the trust's IT department by managers and the issues were resolved. The service had also implemented a caesarean section pathway tool. Managers told us work was in progress with the trust's IT team to streamline the induction of labour pathway and introduce electronic bookings.
- The service had invested in a new electronic patient record. This used the same platform as other trusts in North West London and had the same electronic patient record system. Managers told us the system would be rolled out in 18 months. The digital improvement team were mapping the systems processes at the time of inspection.
- Maternity had also received digital funds from the trust to improve records that were not on the new electronic patient record, such as a fetal monitoring system.

Engagement

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

- The service was engaged with their local Maternity Voices Partnership, this is a team of women and their families, commissioners, midwives and doctors that work together to review and contribute to the development of local maternity care. Staff told us this had continued weekly through the COVID-19 pandemic. The MVP chair was a member of the maternity improvement group. Work was in progress on engaging community groups to increase the representation of the ethnically diverse population the maternity service served. Managers told us the group needed to be further developed to ensure it was representative of the local population.
- Staff told us there had been numerous staff engagement events since the interim director of midwifery had been employed. This included staff engagement meetings and listening events. A staff member told us, "Management are going all out to support staff."

Learning, continuous improvement and innovation

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

- The service had recently made some key appointments. This included the permanent recruitment of a perinatal midwife in January 2021, an audit midwife in August 2021 and a risk midwife in October 2021.

Maternity

- During the COVID-19 pandemic maternity services provided care for multiple pregnancy patients for the local population of Harrow, Brent, Ealing and surrounding areas. The service developed a model of 'one stop care under one roof'. The model was listed as a finalist in a health journal's patient safety awards in 2021 as maternity and midwifery initiative of the year 2020.
- A consultant had submitted a proposal to research inductions at an earlier date in pregnancy. This was work in progress at the time of inspection.
- The fetal medicine unit (FMU) had applied for innovation funding to get new monitors for women receiving ultrasound scans. This would enable women to see a larger screen image of their scans.
- Maternity services were a pilot site for Maternal Mental Health Service (MMHS). The MMHS was an innovative joint programme between North West London NHS mental health services and maternity services. The programme combined maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience.

Areas for improvement

SHOULDS

Maternity services:

- The trust should ensure there are enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- The trust should ensure all staff are up to date with all mandatory training, including safeguarding training.
- The trust should ensure staff observe control measures and ensure equipment marked as clean is clean.
- The trust should ensure resuscitation trolleys have out of date equipment removed.
- The trust should ensure cold cots are repaired promptly and operational.
- The trust should ensure triage log sheets cannot become detached from women's notes.
- The trust should ensure 'Time alone' records are fully recorded at every antenatal appointment.
- The trust should ensure drug vials are not inappropriately stored.
- The trust should ensure women have access to antenatal classes.
- The trust should ensure there is a system of triage which records the time at which women with concerns have previously called.
- The trust should ensure they address delays in the induction pathway for transfers of women.
- The trust should ensure there is a clear policy and pathway for women who should go to triage and women that should go to the maternity day assessment unit (DAU).
- The trust should forge a period of leadership stability by making permanent senior leadership appointments to the maternity team
- The trust should develop a strategy for the maternity service beyond the current maternity improvement plan.

Maternity

- The trust should complete its review of its maternity governance structure to incorporate the early improvements noted and to make the structure focus more on safety and quality
- The trust should ensure that early signs of improvement are embedded.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC inspection manager, CQC assistant inspectors and specialist advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.