King's College Hospital NHS Foundation Trust

King's College Hospital

Inspection report

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Date of inspection visit: 1-11August 2022
Date of publication: 23/12/2022

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
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 King's College Hospital

Requires Improvement 

King’s College Hospital (KCH) is part of King's College Hospital NHS Foundation Trust. The trust provides local services primarily for approximately 1,008,700 people living in the London boroughs of Lambeth, Southwark, Bromley, Bexley and Lewisham.

KCH maternity service is a tertiary unit taking referrals for fetal medicine, women with abnormally invasive placenta, hypertension, liver disease, renal disease and other co-morbidities. The service provides midwifery and consultant led maternity care for women. From August 2021 to July 2022, there were 4,191 births in the maternity service.

The service offers women a choice of three different places of birth; the midwife led unit, the consultant led unit or home birth.

King's College Hospital NHS Foundation Trust employs around 11,723 whole time equivalent staff. The trust is a teaching centre for both medical and midwifery students.

We carried out an unannounced inspection of the KCH 01, 02 & 11 August 2022.

During the inspection our team visited the labour ward; postnatal wards; antenatal ward; birth centre; triage unit; transitional care; maternity day assessment unit; neonatal unit, and community midwife services. We also visited maternity theatres to observe an elective caesarean section with the woman’s verbal consent.

We spoke with 45 members of the maternity team including: maternity assistants; junior doctors; registrars; consultant obstetricians and anaesthetists, and student midwives. We also spoke with band six and seven midwives, specialist midwives, consultant midwives, safeguarding and perinatal mental leads for maternity, matrons and triumvirate. We reviewed five full sets of women maternity records and prescription charts. We received feedback from three women who had used the maternity service. We reviewed a range of policies, procedures and other documents relating to the running of the service. We observed various handovers and multidisciplinary team (MDT) safety huddle meetings.

We last inspected this service in 2019 and rated it as good overall. We rated safe as requires improvement and rated effective, caring, responsive and well-led as good.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we issued a trust wide letter of intent. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in 2019. The trust took immediate action to address the concerns and we received information to demonstrate this.

Maternity

Requires Improvement ↓

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

- The service did not control infection risk well. Staff did not always follow best practice to protect women, themselves and others from infection. Staff did not always assess risks to women, act on them and keep good care records. The service did not manage medicines well. The service did not manage safety well and learnt lessons from them. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it.
- Although staff understood how to protect women and had training on how to recognise women, not all staff had completed the mandatory safeguarding training and not all staff were aware of the baby abduction process. No recent simulations of obstetric emergencies and baby abduction drill had been conducted within the hospital and community setting in the service for over 12 months at the time of inspection.
- The design, maintenance and use of facilities, premises and equipment did not always follow safety standards. The service did not always maintain, service or replace equipment. Some equipment safety checks were out of date and daily checks had not always been completed.
- Policy and guideline documents were not always reviewed in line with their review date. Managers did not always appraise staff's work performance to make sure they were competent for their roles. The service had not fully implemented some of the national recommendations aimed at keeping women and babies safe. Leaders did not always effectively identify and mitigate risks to the service. There was no systematic approach to prioritising women who attended triage. The service was not always committed to the improving the care and services provided for bereaved parents.
- Staff treated women with compassion and kindness and took account of their individual needs. The trust performed worse than other trusts for 12 questions in the CQC 2021 maternity survey and was highlighted as one of eight 'worse than expected' trusts in England.

However:

- The service had enough obstetric staff to care for women and keep them safe. Doctors, midwives and other healthcare professionals worked together as a team to benefit women. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- Staff treated women with compassion and kindness. They provided emotional support to women, families and carers. Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Key services were available seven days a week.
- Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of women receiving care. Leaders and staff engaged with women, staff, equality groups, the public and local organisations to plan and manage services. All staff were committed to continually learning and improving services.

Is the service safe?

Requires Improvement →←

Maternity

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

Mandatory training

The service provided mandatory and maternity specific training in key skills to all staff but had not made sure everyone completed it. Completion rate for obstetric staff was significantly below the trust target.

Staff did not always receive and keep up to date with their mandatory training. This was not an improvement from the last inspection. The overall mandatory training for staff as of 2 August 2022 was 86.8%. In the data provided to us post-inspection, it was unclear what the trusts target was for overall compliance with mandatory training.

The hospital also provided doctor and midwives (including community midwives) with maternity specific skills training and signed off competencies in addition to mandatory training. This covered areas such as fetal monitoring, blood transfusion, practical obstetric multiprofessional training (PROMPT), perinatal mental health and cardiotocography (CTG) training. The data provided from the trust for the PROMPT training showed that 60% of midwives, 91% of consultants, 45% of junior doctors, and 5% of anaesthetist had completed the training. Staff told us the poor compliance of anaesthetists had been escalated to the trust board but was not on the risk register. The trust informed us they had an action plan in place to improve staff compliance and as of November 2022, 66% of the junior staff and 87% of consultants would have completed this training.

The maternity specific training data showed 75% of midwives had completed the blood transfusion training. No data was provided for doctors for the blood transfusion training. The maternity training data for fetal monitoring showed 78% completion rate for obstetric staff, 90% for midwives and 100% for temporary staff.

Community staff told us they had not had an emergency since 2019, but there had been one for hospital staff in 2021. Staff told us they had been unable to carry out planned skills in the maternity service due to availability of staff.

Managers did not have oversight nor monitored mandatory training for staff. Senior maternity staff we spoke with did not have an oversight on the completion rate of mandatory training for midwives and obstetric staff. Managers did not know what the mandatory training rates were and we were told the oversight of the doctors, midwives and maternity support workers mandatory training compliance was managed by different people, which made it difficult for leaders to know what the compliance in their areas were.

The service had a lead midwife responsible for learning and development, who did not have access to the trust learning and development system and as a result there was lack of oversight on staff compliance.

The mandatory training was comprehensive and met the needs of women and staff. Topics included resuscitation, fire safety, training conflict resolution, equality & diversity, safeguarding adults and children as well as other relevant topics. The majority of the training was delivered by e-learning, although there was some face to face modules.

Clinical staff completed training on recognising and responding to women with mental health needs and cognitive impairment. Specialist midwives provided this training. As at 2 August 2022, 93% of midwives had completed the perinatal mental health training. We asked for the perinatal mental health training data for doctors, but the trust did not provide this data.

Safeguarding

Maternity

Although staff had training on how to recognise and report abuse and they knew how to apply it, not all staff had completed mandatory safeguarding training. Staff were unaware of the baby abduction policy and had not completed a baby abduction drill for over a year.

Staff received training specific for their role on how to recognise and report abuse but not all staff had completed safeguarding training. Training data received during inspection showed maternity staff had achieved 97% on the safeguarding adult level 1 training and 84% on Level 2 safeguarding adult training. Staff achieved 83.3% completion on the safeguarding children level 2 training, 86.1% on safeguarding children level 2 and 71% on safeguarding children level 3 training. The trust told us they had plan to ensure staff completed safeguarding training by the end of August 2022 as part of their appraisal pathway.

Not all staff were aware of the baby abduction policy and staff told us there have been no baby abduction drills across the maternity service for over a year. We recommended the service consider implementing a process to ensure staff were aware of what to do in a baby abduction situation. Following the inspection, we saw evidence the trust had emailed all staff a copy of the baby abduction policy and a baby abduction drill had been carried out 11 August in the maternity service.

On our first visit, entrance to the maternity areas such as birth centre, labour ward, women's surgical unit, antenatal and postnatal ward were not manned by staff or security staff. We observed that it was easy for women and visitors to enter and exit the maternity areas without being seen or challenged by staff, which increases the risk of baby abduction in the unit. When we returned to the hospital on 11 August, we observed security personnel had been assigned to the maternity areas. Our identification was checked on arrival before we could access wards and we saw checks were made on others before entering.

The trust had safeguarding policies, guidelines and pathways in place that guided staff on safe practices. We reviewed the safeguarding adult and children policies, which were in date and included relevant national legislation. However, the policies did not include contact details of internal staff and external organisations, staff could contact if they had any concerns. There was no escalation flow chart in the safeguarding policy. Following the inspection, the trust told us that the contact details of all safeguarding leads were available to staff on the trust intranet.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew the named midwife and obstetric staff for safeguarding in the hospital and how to access them for support.

Staff could give examples of how to protect women from harassment and discrimination, including those under the Equality Act. Staff provided examples of where they had made referrals or escalated their safeguarding concerns to protect women and babies with complex backgrounds. From the records reviewed we saw evidence of safeguarding referrals and involvement of multiprofessionals such as social services, GP and health visitors where safeguarding concerns had been identified.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always adhere to control measures to protect women, themselves and others from infection. The equipment and the premises were not always visibly clean.

On our initial visit we found ward areas were not always clean and did not have suitable furnishings which were well-maintained. Not all areas we visited were visibly clean and uncluttered. We found some mattress's, curtain and chairs,

which had rips, stain and tears and did not conform to infection prevention control (IPC) standards. These were highlighted to staff; however, staff were unsure how curtains should be changed and when we inspected the next day the curtain had not been changed or removed despite inspectors raising this with the infection control lead. We did not identify any concerns with cleanliness of the environment or equipment on our return visit on the 11 August.

Cleaning records for toilets and bathrooms were observed in the maternity areas including women's toilets and did not demonstrate that all areas were cleaned regularly. There were gaps in daily checklist in the cleaning log reviewed. We found dirty and dusty CTG machines in triage and labour ward during inspection. Both times matters had been addressed by our return visit to the service.

We found blood stains in two bathrooms which were visibly dirty and identified as cleaned and ready to use. There was no evidence that staff completed cleaning and room preparation checks in accordance with policy. We were not sure how long the blood stain had been in the bathroom and this was escalated to staff. Therefore, were not assured the service was operating a cleaning schedule or monitoring the level of cleanliness in the patient's toilet and bathrooms. We escalated our concerns to the trust and following the inspection we were informed a cleaning review had been undertaken.

Staff did not always clean equipment after patient contact and did not always label equipment to show when it was last cleaned. Green 'I am clean' stickers were not always in use in all the maternity areas visited. There was inconsistency in the use of the green 'I am clean' stickers and these were either not used, out of date or always updated following the cleaning of equipment across the maternity wards. For example, on the labour ward, one of the empty rooms did not have sticker on any of the equipment. On labour ward: eight equipment had stickers and were in date, 11 equipment items did not have labels and three pieces of equipment had stickers which were out of date. In the birth centre, we saw a handheld doppler which was visibly dirty with gel which had not wiped off and had an 'I am clean' sticker on.

The hospital carried out a uniform audit in the maternity areas for the period of January to June 2022, the result showed staff had achieved 92% compliance on the standards audited. During inspection, we observed that not all staff across the maternity areas were following the trust infection control principles and uniform policy. We found several midwifery, obstetric and senior staff with nail varnish on, false nails, long hair that was not tied back and wore jewellery including stone rings and loop earrings. We escalated our concerns to the trust and following the inspection the trust provided information that showed that a reminder had been sent to staff reminding them of the trust uniform policy. On our return site visit on the 11 August we did not identify any non-compliance with the trust's uniform policy.

We visited one of the community midwives' units during inspection. We noted there was a general lack of IPC controls in the building with staff saying there was insufficient space to keep the environment clean and free of clutter. We observed staff had placed a bucket in one consultation room to collect water as a result of a hole in the building roof. The unit was carpeted throughout, including clinical areas, which posed an infection control risk. Staff told us the walls were not in a good state and needed re-painting. This was escalated to the trust and we were informed post inspection that the hospital had increased the frequency of IPC checks and the hospital team had reviewed the unit. Carpets had been cleaned and the trust was planning to remove carpets following the inspection. We received the trust actions in response to the letter of intent to confirm this. Despite the inspection team seeing the bucket in the consultation room the trust told us the roof was repaired 15 June 2022 and there was no leak.

The mandatory training data showed 89.2% of staff had completed mandatory IPC training. From January to June 2022, staff achieved an overall 90% in the IPC audit. The hospital did not provide data for the cleaning audit.From January 2022 to June 2022, staff achieved an overall 95% in the hand hygiene audit across the maternity inpatient service. The maternity community team had only completed the hand hygiene audit in June 2022 and achieved 62% compliance.

Hand sanitising gel dispensers were not readily available at all entrances, exits and clinical areas in the maternity areas and hospital entrance for staff, patients and visitors to use. However, we observed multidisciplinary staff applying hand sanitising gel when they entered clinical areas and washing their hands between patient contact.

For the period of August 2021 to July 2022, there was once case of community acquired MRSA (antibiotic resistant bacteria) and one case of hospital acquired Clostridium difficile. There were seven E. coli cases reported for the women's care groups for June 2021 to June 2022. From January 2022 to July 2022, the women's care groups which includes gynaecology scored 100% in five of the standards audited in the Care of intravenous (IV) lines and scored 70% on the documentation of IV lines against a target of 95%.

Staff followed infection control principles on the use of personal protective equipment (PPE). The maternity service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. From January 2022 to June 2022, staff achieved an overall 92% in the PPE audit and using a red amber, green (RAG) rating system the trust was rated as amber in January, March and April 2022.

Women who were booked for elective caesarean section (c-section) were screened for MRSA during their pre-operative assessment appointment. The five women's record we reviewed confirmed that MRSA screening was completed when indicated.

Staff carried out the decontamination of surgical instruments in accordance with national guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date and daily checks were not always completed. The community service did not have emergency equipment.

Call bells were not available in every patient bathroom and maternity areas. In the triage area, a woman was left unattended for a long time and told us she did not have a call bell and did not know to call the midwifery staff for support. We observed three patient's toilets did not have an emergency call bell contact for help during an emergency despite there being a sign on the bathroom door asking for patients to pull the call alarm if assistance was required. There was a mixture of ligature free call bells and pull cord lights in some bathrooms but non-ligature free in others, which posed a risk to individuals who may be experiencing mental health concerns. We highlighted this safety concern to senior management and were told, the hospital will ensure all bathrooms have call bells and ligature risk call bells will be replaced within few days. During a follow up visit to check on progress with concerns raised to the trust, we saw these changes had been made.

The service did not always maintain, service or replace equipment. We were concerned that some equipment was fit for purpose, properly maintained and there was no suitable arrangement in place for the replacement or maintenance of equipment. We found several items of equipment across the maternity areas, such as resuscitaires, warming machines, breast pumps, circulation equipment, CTG machines used for blood circulation and oxygen saturation monitors which had not been electrical safety tested or serviced to ensure it was safe for use. For example, three fridges in the maternity areas had not been maintenance checked, six CTG machines on labour ward had not been portable appliance tested (PAT) and CTG machines in triage were last checked in 2018 for calibration and electrical safety testing. We found over 30

pieces of equipment which had not been serviced or electrical safety tested. This was escalated to the trust and we were informed post inspection that all equipment which had not been serviced or electrical safety tested had been removed from the maternity wards. The trust also told us the hospital would be prioritising the maintenance and safety testing of clinical equipment.

We noted on the return site visit on 11 August equipment had been safety tested and stickers were attached to demonstrate this. Some items were yet to be serviced and there was a plan to do so.

The service did not always have enough suitable equipment to help staff to safely care for women and babies. Staff on the ward told us they did not have enough CTG machines to monitor the baby's heart rate. During inspection, they had two CTG machines for the four rooms in the unit, which posed a challenge and risk when acuity was high. The community midwives centre we visited did not have a defibrillator, grab bag or resuscitation equipment on site.

The corridors of the maternity areas visited were clustered with equipment and full of hazards, which posed a safety concern if a woman needed to be transferred to the operating theatre in an emergency. Staff told us storage was an issue in the maternity areas, hence why some equipment was stored in the corridor. We observed the units' walls were not in good condition and there were marks and scuff marks on them.

Equipment including emergency equipment were not always stored appropriately. We found medical gas cylinders were free standing and left unsecured in rooms and corridors. Two oxygen cylinders were empty despite being placed next to resuscitation equipment on the labour ward. In the community, we found Nitrous Oxide cylinders which were not stored appropriately and kept in a tiny cupboard. There had been no fire risk assessment carried out. On the labour ward, we found an unsecured lidocaine (local anaesthetic) on an instruction trolley and a pre-term grab box containing emergency drugs at the nursing desk. This was kept in areas where women, visitors or public could easily access.

In triage, we observed a resuscitaire which was obstructed by a computer desk and table, which posed a safety risk during an emergency. Staff told us this could be moved but they would take a baby to the labour ward if resuscitation was required, which was not considered safe and posed a safety risk to babies during an emergency.

Equipment was not always fit for purpose and did not always adhere to safety standards. We found a broken resuscitaire stored alongside two others working resuscitaires in the birthing unit and staff were unaware which of these was in use or in use. We were concerned that the broken resuscitaire could be mistakenly taken by staff in an emergency. We saw five chairs in the birthing unit and triage, were ripped and generally dirty that needed to be condemned as they posed a safety and infection risk to those who used them. This was escalated to the trust and we were informed following the inspection the chairs have been removed and environmental checks now formed part of their daily checklist and were being monitored at an operational oversight meeting. The issue of the broken resuscitaires being mixed amongst working ones was escalated to the trust and we were informed following the inspection that the broken resuscitaire had been removed from the unit and the daily checks in maternity areas would include removal of broken equipment.

Staff did not always carry out regular safety checks of specialist equipment and some equipment throughout the maternity department were out of date and not stored in secure areas. There were gaps in the daily check sheet of equipment for the last six months from the records reviewed. Across the maternity areas, emergency equipment and other equipment such as anaesthetic trolley, oxygen cylinders and mattresses were not checked daily.

We found over 25 pieces of out-of-date single use equipment such as tracheal tubes, catheter and neonatal tubes. For example, on the labour ward, we found expired items in the neonatal emergency box and an unlocked adult resuscitation trolley. We found exposed suction tubes in resuscitaires in three rooms on the labour ward and one in

triage, which increased the risk of contamination and cross infection. We highlighted the out of date equipment to senior management. We were told all out of date equipment and empty oxygen cylinders had been removed, and the emergency trolley had been unlocked. The importance of completing daily checks had been reiterated to staff and medical gas checks had been added to the daily matron checklist.

For the period of January to March 2022, the equipment audit result showed 89% compliance on standards audited. Data submitted by the hospital showed the service had plans to replace 17 CTG and seven ultrasound scanners which were over seven years old. This had been approved and was awaiting a business case. We noted the trust was RAG rated red for equipment below one year expected life and amber or red for equipment with expectancy for one to three years.

Baby breast milk was not kept in a secured environment in line with the trust policy and British Dietetic Association (BDA) guidelines for the Preparation and Handling of Expressed and Donor Breast Milk. We found breast milk was stored in areas where IV dressings and other equipment were kept. We also found opened and unlabelled baby breast milk in the milk fridge, which was easily accessible to other women and their partners. There was a risk of contamination, theft and mix up due to lack of appropriate labelling. It was unclear which breast milk related to which woman and baby. This was escalated to the senior management and following the inspection we saw evidence the trust had reviewed their process, unlabelled milk had been discarded, milks were appropriately labelled and only staff will have access to the milk fridge. The hospital was looking at commissioning lockable fridges on the labour ward.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and took action to remove or minimise risks.

We observed that not all women on the wards were reviewed clinically within appropriate time frames as per the nationally recognised tool used. Staff did not always complete initial assessments on time on admission or arrival and a risk status and oxygen saturation of patients was always documented.

Staff did not always use a nationally recognised tool to identify and assess women at appropriately. The service did not use a nationally recognised risk assessment tool in triage to better assess and treat pregnant women who attended hospital with pregnancy related complications or concerns. Staff told us they had not been properly rolled out a nationally recognised triage tool in the maternity service and this was still in the pipeline. Staff did not always assess women within 15 minutes of presenting to triage as per trust policy. This safety risk was escalated to senior managers and information received post inspection showed that an urgent review of the current triage policy has been undertaken to ensure early identification of deteriorating women. The trust told us the triage risk assessment tool will be implemented in the service by Autumn 2022. However, the maternity service used the newborn early warning trigger and track tool (NEWTT) and modified early obstetric warning score (MEOWS) to identify babies and women at risk of deterioration.

In the maternity assessment unit (MAU) midwives were seen undertaking presentations scans (3rd Trimester scans) without formal training, supervision or competency checks. Staff were aware this was outside their competency. This was raised with senior staff and the trust. Following the inspection, the trust informed us that all midwives had been informed not to undertake presentation scans without formal training and a formal guideline and training programme with competency assessment for midwives who wished to undertake had been developed.

Maternity

The telephone advice service did not contact MAU to inform them, when women had been asked to attend the unit and what the concerns were. MAU staff told us anyone could turn up in the unit and they did not have an oversight of the severity and condition of these women. This posed a safety risk as the unit was located off site and there was no medical staff assigned to the unit in the morning. Staff expressed concerns about the transfer of the care of women to the main hospital as there could be a delay for the ambulance to arrive. Staff working in the telephone assessment service were not providing checks on women who were advised to attend hospital but did not attend, which posed a safety risk to women and unborn babies. These safety concerns were escalated to the senior managers and following the inspection, the trust informed us the standard operating procedure (SOP) had been amended to ensure there was robust communication between each unit; this would ensure those who did not attend (DNAs) were called back.

Staff were not always clear on the escalation measures and process in the hospital. We saw an example of an unwell woman who had not been escalated to the relevant team at night and was later transferred to another unit. Following the inspection, the hospital informed us the escalation policies and procedures would be discussed and reiterated at each handover and the escalation policies had been reviewed and circulated to staff. Posters detailing how to escalate concerns had also been laminated and displayed throughout the maternity areas.

On one occasion, we saw one patient waiting to be seen by a doctor for an unexpected medical complication which had developed in the last few days, post-delivery. The patient was noticed by inspectors to be looking unwell and when asked by the inspection team if she needed any support, she told us that she had not yet been seen by anyone within the unit and was told by the receptionist to sit and wait in an isolated room. No explanation of using the call bell if she felt unwell had been explained by staff. Upon flagging down a member of staff to ask what was happening with this patient's care, the staff member abruptly told us they were unaware of why the patient was in this area, or what their concern was. It was not clear that a doctor had been assigned to review the patient and staff were unaware of why the patient was in the department. Staff agreed with the inspection team that the patient looked unwell and we then ensured staff had escalated the patient's presence to a senior member of staff.

On the postnatal ward we found two babies in their cot placed next to the nursing (midwife) station. One of the baby's was detached from the baby's foot in the crib and the tag only had baby's name. The babies looked similar, which posed a risk of mix up of babies by staff. The staff member we spoke to was briefly unaware of which baby belonged to which parent. This was raised with senior managers and we were given assurance they would investigate this.

Clinical areas were not locked and there was no safety or security precautions in place to protect against unauthorised access and tailgating. There was lack of appropriate level of security, access to and exit the maternity areas particularly the antenatal and postnatal ward area, posing a risk of avoidable harm. This was not an improvement from the last inspection. The postnatal ward now shared space with the gynaecology surgical wards and we observed visitors were buzzed in from the gynaecology surgical wards and other maternity areas without been questioned by staff about who they were visiting. It was easy for a visitor to access the postnatal ward areas from the gynaecology surgical ward and abduct a baby without been challenged or seen by staff. This was escalated to senior management and post inspection the trust told us that a rapid review of entrances and exits had been carried out, staff have been reminded to challenge all individuals entering the maternity areas and swipe access will be reactivated on some clinic room doors. The hospital had introduced a static 24/7 security presence to the maternity areas from 9 August 2022 to enhance security, and we saw correct checking processes were in place to avoid unauthorised access when we revisited.

We found open storage cupboards in areas where women, partners and relatives were left by themselves. The storage cupboards included sharp objects such as scissors and needles and posed a safety risk to women, relatives and babies and this was not on the risk register. This was escalated to senior management. Post inspection, the trust told us a risk

assessment had been completed and in order to access these rooms during an emergency the storage cupboards would need to remain unlocked until swipe access was installed. All abandoned objects had been removed from corridors, and this would be checked daily by staff. All areas with storage units containing sharps and scissors would have swipe access in future.

Staff we spoke to including senior staff were unclear when the service last audited compliance to safer surgery World Health Organisation (WHO) checklists. Post inspection, the hospital submitted the women health care groups score card for the WHO checklist for the period of July 202]. to June 2022. The result showed 93% compliance against a target of 95.4%. We observed an elective c-section and saw staff adhered to the WHO '5 steps to safer surgery' checklist.

Staff knew about and dealt with any specific risk issues such as sepsis and venous thromboembolism (VTE). The service completed VTE risk assessments, used to determine a risk of developing a blood clot. The Women Health Care Groups score card for the period of July 202]. to June 2022 showed the care group met its target for VTE risk assessment and care of IV lines. Although, there was poor documentation on the recording of the care of the IV lines, with a completion rate of 70% against a trust target of 95%. In all the women records we checked; staff completed risk assessments for venous thromboembolism (VTE).

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 band 7 staff, including the specialist and consultant midwives, were responsible for assessing and managing high risk patients. The consultants and specialist midwives held regular high-risk obstetric clinics for women who had medical issues or conditions such as a high body mass index (BMI) or birth trauma.

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 mental health pathway which guided staff on steps to take where a patient was at risk of committing suicide or harming others.

Staffing

The service did not always have the planned number of midwifery and nursing staff to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough medical staff to keep women and babies safe but did not always have enough nursing and midwifery staff on shift. During inspection, we observed the number of midwives and nurses did not always match the planned numbers on labour ward, transitional care, triage, antenatal and postnatal ward.

Transitional care did not have a neonatal nurse to look after babies, which meant there was a relevance on midwives to support mother and baby. This was on the trust maternity risk register. On the day of inspection, no staff member was able to identify who oversaw the transitional care. The trust acknowledged the service did not have the required number of neonatal nurses to cover the five designated beds due to vacancy. The trust informed us the vacant posts had been recruited to, and new staff were yet to start in the coming weeks. The trust had put an immediate action in place to manage this risk, for example all babies meeting the criteria for transitional level care would be reviewed and risk assessed by a neonatal doctor or nurse daily.

Maternity

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Although staffing levels were displayed on the wards we visited, staff did not always update the planned number and the actual number of staff to indicate the arrangements.

Managers accurately calculated and reviewed the number and grade of nurses, MSW's and support staff needed for each shift in accordance with national guidance. The hospital used the Birthrate plus tool to monitor acuity. Staffing was reviewed at daily huddles and any staff shortages were escalated to matrons, labour ward coordinators, flow midwife and matrons in and out of hours. Community and specialist midwives were used to cover any gaps in the maternity areas particularly the labour ward to ensure one to one care was achieved for women in active labour.

The service had high vacancy rates. The trust average turnover rate for the maternity service from January to June 2022 was 14.5%. The trust had an action plan in place to improve the staffing levels cross-site and had recently recruited 50 midwives which were due to start by the end of 2022.

The service had high turnover rates. The trust average turnover rate in the maternity service from January to June 2022 was 12.3%. Staff felt the rotation of staff in the service had helped improve the midwifery staffing and retention.

The service had reducing sickness rates. The trust average sickness rate for the period January to June 2022 for the maternity service was 5.7%. The sickness rate had improved in May and June 2022 compared to the previous months.

Managers used bank and agency staff to fill gaps and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The service had high rates of bank and agency staff. For the period of January to June 2022, there were approximately 4,533 shifts filled by agency and bank staff for the maternity service. The service had filled 842 shifts with agency or bank staff in June 2022. The trust women health care groups score card for the period of June 2021 to June 2022 showed the average fill rate for day shifts was 92.2% against a 93.5% target and the fill rate for shift was 94.8% against a target of 95.6%.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007). For the period of January to March 2022, 99.4% women received one to one care during active labour. Staff told us one to one care in established labour was good and had been maintained for the past months.

Records

Records were not stored securely and not all information relating to patient care and treatment was documented. Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Staff in the MAU told us they had no connection in their unit and as a result staff could not upload diagnostic scans into electronic records. Staff told us they have raised this with their managers, but nothing had been done about this.

Records were not kept, maintained and stored securely in the maternity areas. Across the maternity wards, paper records were not always stored securely in locked trolleys and were left in open areas which could be easily accessed by an unauthorised person. There was a general lack of patient confidentiality with patients' electronic records displayed on open desktop computers, and staff did not log off from their computers when systems were not in use across the

maternity areas. In the introduction area, we found clinical information relating to two women written on paper towels by staff and left on a trolley with no patient name. There was a risk of mix up of patient data. The handover boards were displayed in open view and easily accessible to unauthorised people. This was escalated to senior managers and post inspection we saw evidence actions were taken to address this including new lockable notes trolley delivered to maternity areas, use of roller blind for the handover boards and a reminder sent to staff on the good practice for the management of patient records. The hospital had also implemented an automatic screen lock of electronic records when not in use after three minutes in inpatient areas and five minutes in outpatient areas.

Women's notes were comprehensive, and all staff could access them easily. We reviewed five maternity records for women at different stages of the maternity pathway and found records were mostly comprehensive, but not all risk assessments and clinical assessment were documented such as oxygen and risk status.

The maternity service carried out a record audit for the period of January to March 2022 to assess documentation and confidentiality in the service. The result showed 86% overall compliance on the standards audited.

When women transferred to a new team, there were no delays in staff assessing their records. We saw that discharge summaries were sent to health visitors and GPs. We saw that staff communicated effectively with community staff where there were safeguarding, mental health, domestic violence and specific mother or baby concerns.

Medicines

Although, the service used systems and processes to safely prescribe, administer and record medicines, medicines were not always stored and managed safely.

Medicines including emergency and anaesthetic drugs were not stored securely and safely managed in line with the trust policy and current legislation and guidance. Staff did not recognise the need to lock medicines away. Medicines were left in open areas where women using the service and visitors could gain easy access. For example, on the labour ward, we observed two store cupboards were unlocked and we found several unsecured medicines such as vitamin k, oxytocin (used for inducing labour), antibiotics, sterile gel containing local anaesthetic and anaesthetic spray, which can result in drunkenness, urethra and hallucinations. We also found medicines such as vitamin k and intravenous (IV) medicines in an unsecured area in recovery and labour ward. We found loose medicines such as asthma inhaler and medicines used to induce labour without their packaging in an unsecure drawer on the labour ward, in areas that were easily accessible by staff, patients and visitors. The unsecured medicines found were given to staff by the inspection team. We escalated our concerns to senior managers and post inspection we saw evidence that the trust had put an immediate action in place to address this. During a follow up visit to check on progress with concerns raised to the trust, we saw medicines were stored in accordance with trust policy.

There was no audit of medicines taken off site by community midwives. This was raised with the trust and following the inspection the trust informed us that all medicine cupboards were tired and locked immediately. A medicines and safety audit would be carried out in all maternity areas including audit on medication taken by community midwives.

Across the maternity areas, daily checks for ambient fridge temperature and clinical room temperatures where medicines were stored were not completed in accordance with the trust policy. For example, there were at least 69 omissions between December 2021 to August 2022 on the fridge and temperature checks on the labour ward. This was escalated to senior managers. Following the inspection, we were told the matrons had carried out visible checks of fridge and clinical room temperature. The hospital will be carrying out an audit on the new checks in place and report findings to the weekly operational oversight meeting.

Maternity

No medicines incident was reported for the period of June 2021 to June 2022. During inspection, staff told us there had been a reported incident the previous week for medicines error which was also linked to staff shortage.

For the period of July 2021 to September 2021, the medicines audit showed 81% compliance on the medicine's safety and security audit, against the 16 standards audited. The service only met their target on six standards audited and rag rated amber on five standards and red for seven standards. The standards the service scored worse included medical gases being secure, monitoring of clinical room temperature, medicines stored in original packaging and fridge temperature monitoring. The recent medicines management audit for April 2022, showed the service achieved 89% compliance.

For the period of July 2021 to September 2021, the service achieved 88% on the controlled drugs audit and 95% on the compliance with the medicine's national safety alerts.

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all prescribing documents safely.

Staff completed medicines records accurately and kept them up to date. We reviewed five prescription charts for women on the wards and found that these were accurate and up to date. All prescriptions were signed and dated with legible writing used throughout. Staff recorded allergies including medicine allergies in patient records.

Staff followed national best practice to check women had the correct medicines when they were admitted or moved between services. The pharmacists and midwives checked and reviewed women's' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.

Incidents

The service did not always investigate incidents in a timely manner and did not always manage safety incidents well. We were not assured that staff always recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always know what incidents to report and how to report them. Staff did not always raise concerns and report incidents and near misses in line with trust policy. Some staff felt there was a low reporting culture in the service and staff only reported concerns such as low staffing on shifts when they were upset. Staff including senior staff were unaware of what maternity red flags and trigger list for submitting an incident were. We became aware of a serious incident in transitional care, where a baby was not escalated appropriately during the night and later deteriorated and was transferred to neonatal intensive care unit (NICU). Staff were unsure if an incident form was completed. This was escalated to the senior managers. Post inspection, we were informed an email had been sent to staff on the importance of the escalation of deteriorating patients, an incidents trigger list had been developed and an incident form had been completed by staff.

Managers did not always investigate and close serious incidents in line with the trust policy. This was not an improvement from the last inspection. The trust had a backlog of 32 open maternity serious incidents (SIs) and Healthcare Safety Investigation Branch (HSIB) incidents awaiting either review or action plan reviews. There were 13 non- HSIB maternity SIs across both hospital sites and 10 of the SIs occurred between March 2021 to December 2021. Some senior staff involved in the investigation of incidents reported they had not undergone any specific incident

investigation training; incidents investigations were not always allocated and there was lack of cover for managing maternity incidents investigation when staff were on leave. This was escalated to senior managers and post inspection. We were informed that the Chief Executive Officer (CEO) had agreed to the need for additional hours to clear the backlog of the SIs by the end of September 2022.

Most staff were unaware of recent reported maternity incidents and learning from incidents in the service. Learning from incidents were generally shared with staff at team meetings and newsletters. We saw evidence of learning from incidents included cord prolapse, VTE in pregnancy and puerperium and clexane doses and signs and symptoms of DVT. We observed that displayed posters of learning from incidents in the maternity areas were not updated regularly and some information was dated December 2021. This was escalated to senior managers and post inspection we saw evidence the labour ward noticeboard had been updated with learning from incidents.

Managers did not always debrief staff after serious incidents. Staff told us of a lack of a structured debrief following serious incidents. Staff did not always meet to discuss the feedback and look at improvements to patient care, this was mainly due to staffing issue and lack of tam. Community staff reported that learning from incidents was not routinely shared as compared to staff within the main hospital. This was escalated to senior managers and post inspection we were informed a review would be undertaken to focus on community sites, and a learning event was to follow.

The service had reported eight serious incidents within the service. Managers investigated incidents thoroughly from three serious incidents reviewed. Women and their families were involved in these investigations.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong from the serious incidents reviewed.

All still births and neonatal deaths were investigated and reported to the MBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) in line with the national guidance. From January to May 2022, the service reported four neonatal deaths in the service. MBBRACE launched the perinatal mortality review tool kit (PMRT) and the service used this tool to review perinatal mortality. MDT staff reviewed and discussed patient deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites. Examples of change in practice following learning from death include enhanced bereavement training for neonatal staff around care after death and three MDT training sessions on care after death delivered by Pan London lead nurse for complex and bereavement care of staff.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national or local guidance and evidence-based practice. Staff protected the rights of women subject to the Mental Health Act 1983.

Maternity

Staff did not follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies and guidelines relating to the maternity services and found these were not always up-to date and did not reflect current national or clinical guidance. For example, the trust guideline on The prevention and management of antenatal and postnatal thromboembolism' was last ratified 16 October 2018 and next due for review in March 2024 and does not reflect the current National Institute for Health and Care Excellence (NICE 2021) guidelines. Over 20 policies and guidelines reviewed were out of date such as the care of women with pregnancy loss, safer transfer of patients and management of deliberate self-harm patient's policy and procedure. The MAU did not have an escalation process or policy and the MAU emergency transfer was out of date. This was not an improvement since the last inspection.

We saw the internet did not have a clear list of policies and guidelines related to the maternity service. Staff told us there was no list of the policies, guidelines and protocols relating to the service and when they needed any clinical guidance, they searched on the intranet. This made it difficult for student midwives or preceptor to know which policies related to their practice. This was escalated to senior managers and post inspection we were told all out of date policies had been reviewed and policies that were in the wrong place have been moved to the correct place. The trust told us a policy review group would be established to provide oversight of all trust policies and the tracking of all policies would be presented at the trust operation oversight meeting.

There was evidence the trust had used green-top guidelines in the development of policies. Green-top guidelines are national recommendations which assist clinicians and patients, developed by the Royal College of Obstetricians and Gynaecologists.

We saw examples of national and clinical maternity audits having been carried out across the trust, for example induction of labour, avoiding term admissions into neonatal units (ATAIN), shoulder dystocia, pre-term birth and major obstetric haemorrhage audits were undertaken. Action plans were then developed where areas for improvement had been identified. It was unclear if sustained improvements had been made as some audits had only just been resumed following the Coronavirus pandemic.

The service carried out specific local clinical and non-clinical audits such as medicines, VTE risk assessments, records, infection control audits amongst many others. However, local audits were not completed regularly by senior managers to monitor and improve quality and safety of the service. Senior staff could not remember when they last carried out the local audits in their area due to staffing issues as the focus in the past months was around delivery of safe care to women. Staff and senior managers we spoke to did have an oversight of their audit performance. This was escalated to the senior managers and post inspection, the trust informed us audits had been collated and the audit tracker had been reviewed. An audit action plan had been developed and would be monitored at the monthly governance meetings to provide oversight on the completion of audits.

The service had an audit meeting schedule calendar which was reviewed at monthly audit meetings. We saw the trust generally held regular monthly audit meetings expect December 2021, January 2021, April 2022 and August 2022 where the meetings were cancelled due to staff sickness.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. At the multidisciplinary handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Staff referred to signposted women for further support as appropriate.

Women's antenatal and postnatal records showed they received care in accordance with national guidance and standards. For example, the service held regular clinics for women with complex, safeguarding or mental health needs.

Maternity

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. Staff fully and accurately completed women's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor women at risk of malnutrition.

Women and babies had access to dietary and infant feeding specialists, when needed. The service had breastfeeding support workers and volunteers that helped support women with feeding and baby's nutrition.

Women and babies at risk of hypoglycaemia were regularly monitored following delivery to ensure they were, and their blood glucose levels were maintained within the normal range. Women with pre-existing or gestational diabetes were referred to a dietitian with advice given on diet to help control blood sugar levels and weight, in line with national guidance.

Staff supported and advised women on breastfeeding their babies, including positioning and attachment, and hand expression during the antenatal and postnatal period.

Women were given advice on fasting before their elective caesarean section which was in line with national guidance (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*).

The service had achieved UNICEF's Baby Friendly level 1 accreditation.

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Pain relief and control was discussed with women during their birth plan appointment and women were able to choose their choice of pain relief.

Different methods of pain relief such as Nitrous Oxide (gas and air), opioids (such as oral morphine) and epidural anaesthesia were readily available for women in the service. Women were also prescribed non-steroidal anti-inflammatory drugs post-operatively and during delivery to manage their pain.

Staff prescribed, administered and recorded pain relief accurately. Women received pain relief soon after requesting it.

During our inspection we saw there was good anaesthetist cover which ensured women had timely access to pain management. We noted that epidurals were given in a timely manner within 30 minutes and only exceeded an hour in exceptional circumstances.

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 such as National Neonatal Audit Programme, bronchopulmonary dysplasia, large gestational age (LGA), National Maternity Dashboard audit and MBBRACE. Outcomes for women were generally positive, consistent and met expectations, such as national standards.

The trust participated in the 2022 National Neonatal Audit Programme (NNAP). The result showed improvement from the previous year. The trust was within expected range on the mothers who delivered their babies between 23 and 33 gestational age and given at least one dose of antenatal steroids inclusivity and the number of mothers who delivered babies below 30 weeks gestation and given magnesium sulphate in the 24 hours prior to delivery.

The trust participated in the 2021 National Maternity Dashboard audit; the result showed the trust performed similar or better than expected on most indicators audited. The trust performed better than national average on eight indicators, this include babies born preterm, women with vaginal birth following caesarean-section (c-section), babies with first feed of breast milk, skin to skin contact, women who were current smokers at delivery, women with 3rd or 4th degree tear at delivery, women who had a PPH more than 1500ml. The trust performed similar to national average on women who were current smokers at booking.

We reviewed the women's health care groups score card from June 2021 to June 2022 submitted by the trust. The service was meeting the target on breastfeeding at delivery and post health visiting transfer, bookings, percentage of bookings within 10 weeks, ventouse forceps delivery over 37 weeks, home births, vaginal birth after caesarean, induction of labour, number of births below 32 weeks gestation, percentage of women with massive PPH over 1500mls. The service was not meeting the trust target on continuity of care, bookings before 12+ 6 weeks, midwifery led suites births, still births, number of births less than 27 weeks gestation, third and fourth degree tear, unplanned maternal and baby readmission within 28 days, high BMI in pregnancy and smoking at birth.

The hospital participated in the MBBRACE 2021 audit. The results showed the still birth rate was 3.9 (per 1000 live births) which was slightly higher than the England average. The hospital had an action plan in place to improve outcomes. This include quality improvement projects, introduction of fetal wellbeing midwife across site, increase training in fetal monitoring and virtual practical obstetric multiprofessional training (PROMPT) and SIMS training.

The hospital carried out an ATAIN audit between April 2021 and March 2022. The findings showed there were 4,253 registrable births in the maternity areas of which 98.7% (4,253) births were 37 weeks gestation and above. The result showed that 5.1% (213) term babies born in the hospital were admitted to the neonatal unit during this period. This meant the service was meeting the national target for ATAIN admission rate and was also a 0.7% improvement from the previous year. The reasons for admission for admission to admission neonatal units included respiratory (52%), hypoglycaemia (15%), sepsis (6%) and jaundice (5%).

An audit of abnormal antenatal cardiotocography (CTG) audit in 2021 showed the service did not always meeting national and clinical guidelines. The RCOG and NICE guidelines (2011, amended 2021) advised an emergency caesarean birth should be carried out as soon as possible within 30 minutes of decision making for category 1 (immediate threat to the life of the woman or fetus) and within 75minutes for category 2 (maternal or fetal compromise that is not

immediately life threatening). The audit result showed caesarean birth were carried out for Cat 1 between 15 minutes to 43 minutes and 28 mins to 295 mins for Cat 2. Although the result showed an improvement on staff documentation and compliance with category 1 and category 2 of emergency caesarean section. However, the service did not always meet the national and clinical guidelines.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve women's outcomes. We saw evidence the audit findings were shared with staff at meetings, teaching sessions and case study audit meetings. Examples of teaching session carried out in the last 12 months included; sickle cell in pregnancy, Myasthenia Gravis (rare long-term condition that cause muscle weakness) in pregnancy and third trimester rupture of splenic varices.

Competent staff

Managers did not always appraised staff's work performance, made sure staff were competent for their roles and held supervision meetings with them to provide support and development.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. As at 1 August 2022, 48% of staff in maternity had completed an appraisal. This was not an improvement from the last inspection. Although managers supported nursing staff to develop through regular, constructive clinical and restorative supervision of their work, not all staff received regular, constructive clinical supervision of their work. Staff told us the clinical educators were not always visible in clinical areas to provide regular support. Therefore, we were not assured that managers identified poor staff performance promptly and supported staff to improve. This was not an improvement from the last inspection. This was escalated to senior managers. Post inspection, the trust told us there were plans in place to improve compliance by mobilising additional staff support. Data received from the trust post inspection showed the appraisal rate had increased from 48% to 68%.

Staff told us there was no formal inhouse high dependency unit (HDU) training and competence package provided for staff working in the unit. Staff told us there was no guarantee there would be an HDU trained midwife in the HDU unit on each shift. Following the inspection, the trust told us they supported staff to attend accredited HDU courses at local universities and provided in-house HDU refresher courses. However, staff we spoke to were unaware of the in-house HSU refresher courses.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work. There were systems and processes in place to manage staff identified as underperforming. The managers and clinical educators supported the learning and development needs of staff and address any performance or development issues.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw minutes from meetings were comprehensive, noting the actions and recommendations listed at the end of the meeting minutes.

We saw staff such as consultant midwives were actively involved in teaching the service and externally. Midwifery and medical staff we spoke to within the maternity service were up to date with their professional revalidation and had to demonstrate competencies with their managers.

Multidisciplinary working

Maternity

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

The maternity service multidisciplinary team (MDT) worked together with external multi professionals and hospitals to improve patient care and outcomes. Doctors, midwives, midwifery support workers, safeguarding midwives, perinatal mental health midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women's care and treatment.

Staff held regular and effective multidisciplinary meetings to discuss and improve the provision of care to women using the service. Daily safety huddles, ward rounds and handover meetings took place to update staff on plans for women and babies. The handover meeting on the labour ward was held in an open area, which did not promote confidentiality and women and visitors passing by could hear what was been discussed. A safety huddle is a short multidisciplinary briefing to support effective communication, held at a predictable time and place, and focuses on the patients most at risk. The daily safety huddle was not attended by medical staff and was only attended by the midwifery staff, who used the meeting to discuss midwifery staffing and acuity. There was no opportunity for learning and discussion of incidents, clinical cases or risks.

MDT staff spoke highly of each other and the focus on care to improve care and patient outcomes. Staff including the midwives and support staff told us they were treated as professional equals by other MDT staff, medical staff listened to midwives opinion, which helped inform joint decision of plan care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred women for mental health assessments when they showed signs of mental ill health.

Seven-day services

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

All women could report to the hospital in an emergency through the accident and emergency (A&E) department.

Anaesthetic cover was available for emergencies on the labour ward and the maternity service 24- hours a day, seven days a week in line with national recommendations.

There was 24-hour access to a dedicated obstetric theatre, and the theatre team was also available 24-hours a day, seven days a week.

There was 24-hour access to the triage and diagnostic service such as x-ray and ultrasound, seven days a week.

Consultants led daily ward rounds, including weekends. Women were reviewed by consultants depending on the 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.

Health Promotion

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

Maternity

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support on every ward. Staff gave health promotion advice to women on various topics which was evident on patients record reviewed. This included gestational diabetes, alcohol, smoking cessation, immunisation, flu vaccines, Covid vaccines, breastfeeding, safer sleep, healthy eating, vitamin D, sudden infant death syndrome (SIDS) and emotional wellbeing.

The service held regular health promotion classes and workshops to support women and their loved ones. This include infant feeding support classes, antenatal classes and births after c-section workshops.

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.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When women could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records reviewed.

Staff understood Gillick Competence and Fraser Guidelines relating to the assessment of maturity regarding decision making for children under the age of 16. 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.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good ➔➔

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

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and take 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. Women said staff treated them well and with kindness.

Maternity

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

From July 2021 to June 2022, the hospital's maternity Friends and Family Test showed an average response rate of 19.5%, this was better than the trust target of 18%. The maternity service performance was 88.5%, which was lower (worse) than the trust target of against 9.4%. The maternity only achieved the trust target in September 2021, red amber in seven months and rated red in four months.

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 understood the emotional and social impact that a person's care, treatment or condition had on their well-being and on those close to them.

Counselling was also offered for women that experience traumatic birth experience. Women offered antenatal classes and offered emotional support to manage anxiety.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereaved women were supported by the bereavement midwife.

Understanding and involvement of women and those close to them

The trust performed was highlighted as one of eight 'worse than expected' trusts in England in the CQC 2021 maternity survey. Staff did not always support women, families and carers to understand their condition and make decisions about their care and treatment.

The trust performed worse than other trusts for 12 questions in the CQC 2021 maternity survey and was highlighted as one of eight 'worse than expected' trusts in England. This include getting enough information, involved in decision about your care, partners or loved ones involved in the women's care, if concerns raised during labour and birth were taken seriously. As a result of these results, CQC asked for an action plan on how areas of concern will be addressed by the Trust. We will continue to monitor progress through our continuing monitoring and engagement activity. The trust told us that there has since been improvements in the 2022 CQC maternity survey which was published after the inspection was carried out.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women we spoke to during inspection gave positive feedback about the service.

Staff supported women to make informed and advanced decisions about their care. The consultant and specialist midwives were involved with some women to enable them to make informed decisions about their care and treatment.

Maternity

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement

The facilities and premises were not always appropriate for the services being delivered. The service did not always take action to minimise missed appointment and follow up women who did not attend appointments. The service planned and provided care in a way that met the needs of local people and the communities served.

Managers did not always monitor and take action to minimise missed appointments and ensure that women who did not attend appointments were contacted. Women that were signposted to the maternity assessment unit (MAU) by the telephone assessment service were not monitored and staff did not contact the women when they did not attend the unit. We escalated our concern to the senior managers and post inspection, the trust reassured us they had put system in place to address the issues. These matters had been addressed by our return visit to the service and the telephone assessment service team informed the reception and MAU when women were signposted to the unit and followed up with the women if they did not attend.

The facilities and premises were not always appropriate for the services being delivered. For example, the bereavement room was not fit for purpose and appropriate to care for bereaved women and families who have experienced a loss. The bereavement room was in the antenatal ward area, which was a shared space with the women surgical unit. The bereavement room was previously used for admissions and during inspection the we observed the room was also used as a general storage room and not adequately decorated, furnished and designed to give it a homely feel. There was lack of support given to bereaved women and their partner. There was no extra provision for the bereaved partner in the bereavement room.

Staff told us they sometimes cared for postnatal mothers and babies on the postnatal ward if there was high acuity. Having a bereaved mother hearing the cry of other babies was not appropriate. All midwives we spoke to commented on the inadequacy of the bereavement room. Staff told us a debrief service was not readily available for women and a consultant midwife would see women post traumatic birth. Bereavement support was not available seven days a week. Post inspection, the trust told us they were in the process of expanding the bereavement service to seven days and the maternity service currently had two bereavement midwives who provided bereavement support Monday to Friday. The lack of bereavement room provision was not on the maternity risk register. This was not an improvement from the last inspection. This was escalated to senior managers and post inspection we saw evidence that an appropriate bereavement suite had been implemented.

Managers planned and organised services, so they met the needs of the local population.

Staff could access emergency mental health support 24-hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

The service had systems to help care for women in need of additional support or specialist intervention.

The midwifery team provide services in a wide range of community settings and had specialist staff supporting women with issues such as perinatal mental health, migrant women, safeguarding and substance misuse.

Maternity

Meeting people's individual needs

The service coordinated care with other services and providers. However, the service was not always inclusive and did not always take account of women's individual needs and preferences. Staff did not always make reasonable adjustments to help women access services.

Staff made sure women living with mental health problems and learning disabilities, received the necessary care to meet all their needs. Staff supported women living with learning disabilities by using 'This is me' documents (a support tool used to enable person-centred care about a person who can't easily share information about themselves) and patient passports where applicable.

Wards were designed to meet the needs of women living with disabilities. The maternity service had wheelchair access to the wards, accessible toilets and showers which were suitable for people with reduced mobility. The wards had designated rooms that was spacious and adapted to use for women with disability. The maternity services had birthing balls, birthing pools and stool to promote comfort of women in labour.

The maternity service had arrangements in place to support women with complex needs such as learning disabilities, diabetes, sickle cell, cardiac cases, mental health, epilepsy, previous c-section, asylum and high body mass index (BMI). There were specialist midwives dedicated to support vulnerable women with complex needs including teenage pregnancy.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Women were given a choice of food and drink to meet their cultural and religious preferences.

The service did not have information leaflets available in languages spoken by the women and local community. Staff were not clear about the top languages spoken by women who accessed the service. Senior managers recognised the lack of information leaflets in the service and told us the service was currently working on developing various information leaflets in the top five most frequently spoken languages. Therefore, we were not assured that staff made sure women and those close to them understood their care and treatment.

The maternity dashboard was not displayed or updated on all the maternity wards and did not make it easier for women and visitors to understand the performance in the service.

Access and flow

People could access the service when they needed it and received the right care promptly. The service did not always monitor waiting times of women admitted, treated and discharged women in the service in line with national standards.

Women accessed the maternity services via their GP, local children's centre or by direct referral. Patients could also self-refer to the service by the phone or completing a booking form on-line. We reviewed the Women Health Care Groups

score card from June 2021 to June 2022 submitted by the trust. The service was meeting the trust target on percentage of women booked for an antenatal appointment within 10 weeks and home births. However, the service did not meet the trust target for women booked for an antenatal appointment within 12 weeks by 10.9% and continuity of care by 44%.

From December 2021 to May 2022, there were nine units' closures in maternity areas due to reduced labour ward capacity.

From January 2022 to March 2022, 122 babies needed enhanced care and treated under the transition pathway.

From August 2021 to July 2022, 260 women were transferred from the MAU to inpatient maternity service for additional review or admitted to the labour and maternity wards. The number of transfers of women was higher than expected within this period. The reasons for the transfers were mainly related to reduced fetal movement, blood result review, high blood pressure, rupture of membrane and cardiac or respiratory symptoms.

From August 2021 to July 2022, there were nine intrapartum transfers from Princess Royal University Hospital (PRUH) maternity service to the hospital maternity service. This were mainly related to complex cases of women and babies that needed to be supported and cared for in a tertiary unit. In the same period, there were two transfers from the maternity service to PRUH.

Staff supported women and babies when they were referred or transferred between services.

Managers monitored that patient moves between wards were kept to a minimum. The service moved women only when there was a clear medical reason or in their best interest. Staff tried not move women between wards at night.

Managers and staff started planning each woman's discharge as early as possible. Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs.

The hospital had not carried out audits of the waiting times in triage and antenatal clinics. The hospital had not carried out audits on delays in induction of labour and emergency caesarean section. Therefore, we were not assured managers and staff generally worked to make sure women did not stay longer than they needed to.

During inspection, we did not observe any delays of the admission of women to the labour wards, antenatal ward, triage, recovery and theatres.

Learning from complaints and concerns

Although it was easy for people to give feedback and raise concerns about care received however the service did not treat concerns and complaints seriously. Complaints were not always investigated and closed in line with the trust policy.

From August 2021 to July 2022, the maternity service had received 43 formal complaints. These were mainly related to staff attitude, communication of clinical care and breach in confidentiality. No complaints have been referred to the Parliamentary and Health Service Ombudsman (PHSO) in the last 12 months.

Maternity

From July 2021 to June 2022, the trust women's health care groups health score card showed 107 (85.6%) complaints received for the score card were not responded to within the expected 25 days. The open complaints cases for the care group was 14.7% against a target of 10%. Women were informed if there would be delay in the completion of their complaint investigations.

Managers did not always share feedback from complaints with staff to improve the service. Staff were unable to give examples of how they used women's feedback to improve daily practice.

As of 1 August 2022, 67.5% of staff had completed the conflict resolution training.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, they did not always understand and manage the priorities and issues the service faced.

The maternity service was managed as one care group across two sites and the care group reported to the hospital executive team. The trust maternity triumvirate included the director of midwifery, clinical director and general manager. The trust triumvirate were supported by the hospital head of midwifery, service manager and deputy clinical directors.

The trust Chief Nurse was the Executive Director of Midwifery and had regular meetings with the Director of Midwifery.

Most staff were unaware of who the safety champion for the maternity service was. We observed there was no displayed poster of the safety champions and their contact details across the maternity service. The service had a non-executive director of maternity safety champion who had been in post for 10 months and had not conducted a walk around of maternity areas. However, the executive safety champion conducted regular walk arounds with the last one completed last year being described as 'positive'.

Maternity

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Staffing had been a challenge in the service and senior managers across the maternity service had not always been supernumerary and had focused on delivering safe care and achieving one to one care for women in established labour. As a result, this had impacted on the lack of oversight on the service, monitoring of performance and carrying out local audits.

Vision and Strategy

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

The trust women's health care groups aimed to support women and birthing people throughout their lives. They strived to be 'a world leading service providing safe, evidence based, kind and personalised care to all women, birthing people and their families by a valued team that are highly skilled and educated'.

The trust 2022-2024 Women's Health Strategy included brilliant people, outstanding care, leaders in research, innovation and education and diversity, equality and inclusion. This was an improvement from the last inspection when the service had not developed a measurable strategy. The trust had engaged with staff and the maternity voice partnership users in the development of their strategy. The objectives also included the increase in continuity of care to 35% by March 2020, update and relaunch of maternity website, the outcomes and experience data to be visible for the teams to see and to achieve the gold accreditation for the baby friendly initiative (BFI) in the trust.

The women's health care groups priorities were, 'we are a team, we will keep our staff safe and healthy and we are compassionate and inclusive'.

The hospital Maternity Voice Partnership (MVP) were part of the maternity transformation programme in their London Maternity System (LMS) region and were working on various workstreams such as continuity of carer, choice and personalisation, breastfeeding initiative strategy, digital and safer care.

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.

Staff were enthusiastic and passionate about their role and difference they made to the experience of women and their loved ones. All staff we spoke with had a strong commitment to their job and were proud of the team working and positive impact to patient care and experience.

Staff and senior managers recognised how staff had been negatively affected by staffing issues and changes resulting from the COVID pandemic. Senior leaders were proud of staff resilience and how they managed as a team during the Covid pandemic despite the high acuity and complex cases seen in the service.

Staff including student midwifes and junior doctors felt well supported, listened to, respected and valued by their colleagues and senior managers. However, some senior midwifery staff felt undermined by their managers and junior colleagues. One senior member of staff with management responsibilities told us that if the staff below them did not like

their suggestions or ideas, staff would seek a differing opinion or plan from someone more senior. For example, on a day where there was an abundance of staff and few patients, the senior manager instructed staff to complete any outstanding mandatory training, however, staff felt this could be done at a different time and contacted someone more senior to overrule the decision to complete training in favour of doing something else. Sometimes these decisions were overruled, making senior managers feel undermined and unsupported.

The trust had a freedom to speak up guardian. Staff told us they knew their guardians and they would be confident to raise a concern with their managers and were confident this would be investigated appropriately. The service culture encouraged openness, honesty, positive culture of shared learning, innovation and improvement. Staff told us the service was open and transparent and there was a no blame culture when incidents happened, and the team supported each other. However, staff did not always receive debriefs from their managers following serious incidents.

Staff we spoke to were happy about the diverse culture in the team, working in the service and reported no bullying and harassment. Staff told us the MDT teams were very close, respected each other and very united to improve the women outcomes.

Staff felt it was easy to progress and be promoted and we saw evidence of progression of staff since they have been employed in the service.

The hospital participated in the 202]. NHS Staff survey; the women's health care groups result showed that the care groups scored lower than the hospital average on all nine questions audited such as morale, staff engagement, we are safe and healthy, and we are compassionate and inclusive.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The maternity service sought reassurance through various governance meetings in the service, cross-site meetings, HSIB action tracker meeting, care groups meetings and trust board meetings. This included quality review meetings, weekly risk meetings, patient safety meeting, senior team meeting, triumvirate meeting, and women's health board, maternity quality governance meetings and maternity quality governance committee.

The maternity service had a systematic governance process to continually improve the quality of service provided to women. The arrangements for governance processes were clear and staff understood their roles and accountabilities.

Governance management meetings took place in the service and across the site by teleconference to reduce travel. Doctors and midwives said these worked well.

We reviewed various governance meetings and noted they were well attended by senior managers and MDT staff and covered areas such as incidents, staffing, risk register, risk management, complaints, information governance, audits, complaints and patient experience and medicines.

The service did not display the maternity dashboard and performance in all clinical areas. Staff told us the service had purchased dashboards to display their performance and recently recruited a communication midwife who will oversee the updating of displayed dashboards in the maternity areas.

Outcomes of governance meetings were shared with staff through the service weekly newsletter and message of the week which were sent to staff via emails and displayed on the wards. Some bank staff we spoke to stated they did not receive the service newsletter. Staff told us that although message of the week and newsletter were produced, this was sporadic, and information displayed on the wards were not routinely updated. We observed displayed newsletter on the wards, and some were dated December 202.

Managers did not always investigate and close serious incidents in line with the trust policy. The trust had a backlog of 32 serious incidents and Healthcare Safety Investigation Branch (HSIB) incidents across both hospital sites. There was lack of oversight on the allocation of incident investigations to senior staff. The trust was working to clear the backlog of the SIs by September 2022.

In response to a national maternity safety report, the trust had carried out a cross site gap analysis on the maternity services and developed an action tracker to monitor their actions. The trust had benchmarked themselves against 89 actions that the trusts was responsible for. We saw that the trust has RAG rated themselves as green on 33 actions, amber on 51 actions and red on five actions. Actions that the trust rated themselves as red included management of complaints by the maternity team, seven days a week bereavement support provision and change in practice arising from SI investigation seen within six months of investigation. Staff were unfamiliar with this report and told us they had not been included in the planning, nor told of the action plans. Senior staff told us the report and action plan had not been shared with clinical teams and was kept at high level.

We found several safety concerns on the management of equipment, medicines management, confidentiality, ligature risks, uniform compliance and ligature risks. There was lack of oversight on these issues and in some cases, there have been no recent audits carried out by manager to monitor compliance. We escalated our concerns to senior managers. Following the inspection, the hospital had implemented a matron daily checklist that included 2 areas the matrons need to check daily with results to be discussed at governance meetings.

Management of risk, issues and performance

The service did not have robust systems in place to identify all risks in the first instance, and plan to eliminate or reduce them.

Maternity performance measures were reported using the maternity dashboard, which was RAG rated with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. However, the dashboard was not displayed in maternity areas, this meant that staff, women and the visitors were not informed of the outcomes and risks of the maternity service.

There were not effective systems and processes in place to identify risk in the first instance. The maternity service had a risk register and included the hospital and trust wide maternity risks. Risks included lack of neonatal nurse in transitional care, staffing and breaching national target of 18 weeks and cancellation of elective surgery. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register had a risk owner responsible for reviewing and monitoring them, rating, control in place and actions plan. We looked at the risk register and risks were in date and had been reviewed. However, not all risks identified during inspection were included in the risk register such as lack of an appropriate bereavement suite. This was not an improvement from the last inspection.

Staff including service leads were unaware of their top risks and red flags across the service.

Maternity

There was a maternity dashboard and a systematic programme of clinical and internal audit, which were used to monitor risks and quality to identify where action should be taken. However, local audits were not regularly carried out in the service. The audits meetings were not regularly held and there had been cancellation of meetings due to staffing issues.

Information Management

Although, the service collected, analysed, and used information well to support all its activities, information was not effectively managed. Data or notifications were consistently submitted to external organisations as required.

The service had clear performance measures such as key performance indicator (KPI), local and national audits which were reported and monitored. These included the MBRRACE-UK audit, maternity safety thermometer, maternity dashboard and friends and family test (FFT) results. Performance results were discussed at service, care groups and board level to improve care and patient outcome.

The maternity dashboard performance was not displayed on the wards for staff, women and visitors to access.

There was lack of systems and processes in place to support the confidentiality of people using the service and contravene against the Data Protection Act 2018. During inspection we observed staff did not always store and treat patient and staff identifiable information in line with General Data Protection Regulations (GDPR). Records relating to staff were not stored in accordance with current legislation and guidance. Staff records were not always secure and could be accessed by their colleagues who were unauthorised to do so. Staff did not recognise the need to lock computer screens or remove patient sensitive information from public view. This was escalated to senior managers and post inspection we were told all staff records will be held in a secured office. The trust told us they had a plan to phase fully to electronic recording of staff records and additional training would be offered to the maternity team.

As at August 2022, 87.7% of staff had completed the information governance training and 88.4% had completed the data security awareness training.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The maternity service had a functioning Maternity Voices Partnership (MVP) which met regularly and was active in the service planning and delivery. The service had engaged with women and the public on the development of their strategy. Staff reported good relationship with their MVP. We requested for the hospital maternity voice meeting minutes and this was not provided by the trust. The trust submitted survey and report data carried by the MVP in 2020 and where they had engaged with women to get their feedback about the service. We were unclear if there had been any recent MVP meeting in the service.

The maternity held a patient listening event in 2021 and the service received 160 patient experience feedback, which were shared with staff to drive service improvement ideas.

Maternity

The service engaged well with the stakeholders and was actively involved with the South East London Maternity System Maternity Surveillance group (LMS MSG). A representative from the trust attended the meetings. The meeting was attended by other trusts and clinical commissioning groups as well as any other relevant stakeholders such as local GPs, NHS England and local authority representatives.

The service had engaged with BAME staff to obtain their experience in working in the maternity service in England during Covid and beyond. We saw that the trust had developed work streams within the turning the tide national strategic network and hosted mentorship and career development discussion with staff.

The managers engaged with staff through various staff meetings, staff forums, listening events and maternity picnic events.

The service had introduced the role of a communication midwife to help in the dissemination of information to staff, women and public. Staff told us they have seen improvement in communication as this was an issue in the past.

The safeguarding, perinatal mental health and bereavement midwives engaged with external organisations and charities to provide care and support for women with complex or additional needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

The professional midwifery advocate (PMA) had submitted an abstract poster presentation to the Royal College of Midwifery (RCM) in the 2022 RCM conference.

The practice development midwife (PDM) had organised a joint training with the London Ambulance Service (LAS) on emergency training, staff said this had helped equip their knowledge and relationship building and learning.

Staff told us the hospital was planning to introduce a patient safety summit to help in dissemination of information and learning from incidents.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure staff complete mandatory, safeguarding and maternity specific trainings in line with the trust's own target. Regulation 12(1)(2) (a)(c).

Maternity

- The trust must ensure effective processes and systems are in place in the maternity assessment unit (MAU) to ensure women are safe. (Regulation 12(1)(2) (a)(b)(c)
- The trust must ensure the high dependency unit (HDU) was staffed with HDU trained and competent staff. (Regulation 12(1)(2) (c)
- The service must deploy numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of women and babies in the maternity areas and prevent exposing women and babies to the risk of harm. (Regulation 12(1)(2); 18(1)(2)
- The trust must continue addressing the high vacancy rates and high turnover rates for maternity staff. (Regulation 12(1)(2); 18(1)(2)
- The trust must ensure staff complete timely risk assessments for each woman and take action to remove or minimise risks. (Regulation 12(1)(2) (a)(b)
- The trust must ensure staff adhere to control measures to protect women, themselves and others from infection. (Regulation 12(1)(2) (a)(b)
- The trust must ensure equipment is clean, fit for purpose, regularly maintained, replaced and checked in line with trust policy and documented clearly. Regulation 15 (1)(2)
- The trust must ensure emergency equipment such as defibrillators and grab bags are available in the community midwifery centres. Regulation 15 (1)(2)
- The trust must ensure that oxygen cylinders and nitrous oxide are handled and managed securely to minimise risks. (Regulation 12(1)(2)).
- The trust must ensure medicines are managed appropriately, improve compliance on the medicine management audits and medicine storage temperatures are monitored and recorded in line with trust requirements. 12(1)(2) (a)(b)(g)
- The trust must ensure staff report all incidents and a debrief is given to staff and women following a serious incident in line with trust policy. Regulation 12(2)(b); 17(1) (2) (e)
- The trust must ensure senior managers involved in the investigation of incidents and serious incidents were appropriately trained and competent for their roles. Regulation 12 (1) (2)(c)
- The trust must ensure complaints are handled in a timely way and learning is shared with staff in line with trust policy. Regulation 17(2)(e)
- The trust must reflect risk accurately reflects the risks in the service. (Regulations 17 (2)(f))
- The trust must ensure local audits are regularly carried out in the service to monitor service performance and staff compliance with the trust policies. (Regulation 17(1)(2)(a)(b)(f)
- The trust must ensure that all staff participate in the annual appraisal process. Regulation 12(1)(2)(c)
- The trust must ensure that policies, guidelines and procedures are reviewed and follow national guidance. Regulation 17 (1)(2)(a)(f)
- The trust must ensure effective risk and governance systems are implemented which supports safe, quality care. Regulation 17(1)

Action the trust should take to improve:

- The trust should comply with guidance around daily multidisciplinary safety huddles.

Maternity

- The trust should ensure hand sanitisers are available in all maternity areas and hospital entrances.
- The trust should ensure breast milk is stored appropriately in secured areas.
- The trust should ensure the transitional care is adequately staffed by a neonatal nurse on each shift.
- The trust should ensure all women in active labour receive one to one care to ensure the safety of women and babies.
- The trust should ensure that all ward areas have access to internet for staff to complete their daily task.
- The trust should ensure that MAU staff have oversight of women referred to the unit.
- The trust should consider how they display and update safety, quality and performance data to inform staff, women and their families about the service.
- The trust should ensure that the service uses a systematic approach for risk assessing women attending triage.
- The trust should ensure that staff complete patient records appropriately.
- The trust should review and address the number of transfers of patients from the maternity assessment unit (MAU) to the maternity inpatient service.
- The trust should review the current bereavement room and service provision for bereaved women in the service.
- The trust should ensure patient and staff records are stored securely to maintain confidentiality and compliance with the trust policy and national legislation.

Our inspection team

The team that inspected the service on the 1 & 2 August comprised a CQC lead inspector, one inspector and three specialist advisors. On the 11 August an inspection manager and assistant inspector returned to the location to check immediate concerns had been addressed. Both inspection teams were overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out the inspection

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment