Whittington Health NHS Trust

The Whittington Hospital

Inspection report

Trust Offices
Magdala Avenue
London
N19 5NF
Tel: 02072883939
www.whittington.nhs.uk

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Ratings

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

Our findings

Overall summary of services at The Whittington Hospital

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at The Whittington Hospital.

Whittington Health NHS Trust is an integrated care organisation based in North Central London. The trust provides maternity services at The Whittington Hospital to a population of approximately 500,000 people living in Islington, Haringey and those living in Barnet, Enfield, Camden, and Hackney. The maternity service at the hospital comprises of a consultant led labour ward, birthing pools, midwifery led unit, home birthing team, 2 dedicated obstetric operating theatres and recovery areas, antenatal clinic, antenatal and postnatal wards, day assessment unit and a triage area. From January 2022 to December 2022, there were 3,044 deliveries at the trust.

We last carried out a comprehensive inspection of the maternity and gynaecology service in 2016. The service was rated requires improvement for safe and good for effective, caring, responsive and well-led. The service was judged to be good overall. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

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

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

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

Our rating of this hospital stayed the same. We rated it as good because:

- Our ratings of the Maternity service did not change the ratings for the hospital overall. We rated safe as requires improvement and well-led as good and the hospital as good. Our reports are here:

The Whittington Hospital – https://www.cqc.org.uk/location/RKEQ4

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.

Maternity

Requires Improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated this service as requires improvement because:

- Not all medical staff had training in key skills.
- Not all staff had completed their level 3 safeguarding training. Medical staff were not trained to level 3 safeguarding training in line with the intercollegiate guidelines.
- There was no systematic approach to prioritising women and birthing people who attended triage.
- They did not have a dedicated bereavement suite.
- Policy and guideline documents were not always reviewed in line with their review date.

However:

- Nursing and midwifery staff had training in key skills, and staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. They managed medicines well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. A proactive approach to anticipating and managing risks to people who use services was embedded and recognised as being the responsibility of all staff.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- The trust performed similar or better than national average in the 2022 CQC maternity survey, General Medical Council national training survey (GMC NTS, 2022 and mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBBRACE, 2020 audits.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment.
- Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm.

Is the service safe?

Requires Improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement.

Mandatory training

Maternity

The service did not make sure all medical staff had completed their mandatory training. However, the service provided mandatory training in key skills to all staff and made sure all nursing and midwifery staff had completed it.

Medical staff were not up-to-date with their mandatory training. Only 60% of medical staff had completed all mandatory training courses, which was below the trust's 90% target. Senior staff told us that a reminder had been sent to staff that were not up to date with their mandatory training to complete their outstanding training by 31 March 2023. Consultants were required to complete their mandatory training before having their appraisals.

Nursing and midwifery staff completed and kept up-to-date with their mandatory training. Eighty-nine percent of staff had completed all mandatory training courses against a trust target of 90%.

The service made sure that staff received multi-professional simulated obstetric emergency training. Mandatory and maternity specific trainings were comprehensive and met the needs of women, birthing people and staff.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. These training courses included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. A CTG is a continuous recording of the fetal heart rate taken via an ultrasound transducer placed on the mother's abdomen. This training was kept up-to-date and reviewed regularly to ensure it was effective. Staff were meeting the trust target on the neonatal life support, practical obstetric multi professional training (PROMPT), medicines prescribing and fetal monitoring. We noted that staff were almost meeting the trust target by achieving for example, 82% on medicines exemption, 83% on CTG competencies, 83% on face-to-face medicine management and a further 88% in medicines administration trainings. There was also an emphasis on multidisciplinary training among staff which led to better outcomes for women, birthing people and babies.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Practice development midwives, consultant midwife and specialist midwives engaged in staff training and multidisciplinary staff told us their training was updated regularly in response to any local incidents or risks identified in the service.

Safeguarding

Not all staff had completed their safeguarding training. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Not all staff had received training specific for their role on how to recognise and report abuse. Training records showed that not all staff had completed both Level 2 and Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. The intercollegiate guidelines highlight that clinical staff who were patient facing and working with children, young people and/or their parents should receive level 3 safeguarding children training. Medical staff were only trained to level 2 safeguarding children and staff working in the maternity theatre were only trained to level 2 safeguarding adult and children's trainings. The senior managers told us that they had a low threshold for staff contacting the safeguarding team, who were trained to level 4 safeguarding and supported the multidisciplinary team (MDT) team with safeguarding concerns.

The overall completion rate for the level 3 safeguarding children training was 68% against the trust target of 90% as of 15 January 2023. Training data showed a 50% low compliance among the recovery midwives. We raised our concerns with

the trust on the low completion rate for the safeguarding training. The trust told us they were in the process of updating their MDT profile on their training system which will ensure the safeguarding training were completed by staff as part of their mandatory training. However, 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.

The overall completion rate for the safeguarding adults' level 2 training was 78% and for the safeguarding children level 2 training was 88%.

Staff attended regular bespoke safeguarding teaching sessions and multi-disciplinary team meetings to discuss cases involving domestic abuse, peri-natal mental health, homeless pathways, high risk safeguarding cases and support in making safeguarding referrals.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff understood safeguarding procedures, how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could turn to for support when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

The trust had clear systems, processes and practices to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The trust had safeguarding policies, guidelines and pathways which guided staff on safe practices. For example, staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secured, and doors were monitored to prevent and/or minimise abduction risk. The service had updated their baby abduction training and practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. There were systems to ensure the deep cleaning of rooms following a discharge or transfer. Cleaning records were kept up-to-date and demonstrated that all areas were cleaned regularly.

Maternity

We observed staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. From December 2022 to January 2023, staff achieved 97% compliance. The birth centre, antenatal clinic and labour ward consistently achieved 100% within this period.

From December 2022 to January 2023, staff achieved 100% compliance on the intravenous (IV) lines and urinary catheter audits. In the same period staff achieved an overall 94% compliance on the infection prevention control (IPC) audit against the trust target of 90%. However, we noted that the labour ward had a low compliance of 76% in the IPC audit. Senior staff told us an action plan was in place to address the issues found in the audit to increase compliance.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas.

Staff cleaned equipment after contact with women and birthing people and labelled equipment with “I am clean” stickers to show when it was last cleaned. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The environment was not designed to meet the needs of all women and birthing people. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service did not always have suitable facilities to meet the needs of women and birthing people's families. The labour ward rooms were not ensuite, there was a communal shower and toilets, however these may not always be meeting the needs, privacy and dignity of women and birthing people.

The service had a dedicated bereavement suite to care for bereaved mothers and their families, however this was not in line with best practice guidelines. Bereaved women and families were cared for in rooms on the labour ward or birth centres and these rooms had not been adequately decorated or furnished with the facilities needed to support them through bereavement. Despite this, staff told us the bereaved women, birthing people and their families were cared for and supported in a quieter area of the ward.

However, some of the bathrooms observed were not ligature free and there was a mixture of ligature free loose blinds cords which could pose a risk to individuals who may be experiencing mental health concerns. There was no environmental ligature risk assessment following the national patient safety alert on 3 March 2020. This concern was highlighted to senior management during our inspection.

The maternity unit was fully secure with a monitored entry and exit system, and women and birthing people could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionnaires' disease.

Maternity

The service had enough suitable equipment such as portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment to help them to safely care for women and birthing people and babies.

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

The service had designated rooms in both their high risk and low risk clinics used for counselling women and birthing people and breaking of bad news; these rooms were adequately furnished.

The staff, mangers and trust leaders were aware of these concerns which had been added onto the service and trust risk registers, board assurance framework and trust estate strategy. As part of the trust maternity and neonatal estate strategy and improvement programme, the hospital had plans in place to ensure the maternity wards were refurbished to the latest national standards. The trust had secured funding for the phase zero and phase 1one of the maternity and neonatal building programme, which focused on the refurbishment on the birth centre, triage, labour ward and launching a new bereavement suite. Staff were aware of the refurbishment programme and plans for the maternity services.

There were two dedicated obstetric theatres in the maternity unit, which was in line with safe practice and had necessary equipment. Since the last CQC inspection, the service had launched a second new modern obstetric theatre with a recovery area in the service to support women having a caesarean section. The theatres were accessible 24 hours a day for an emergency caesarean section and appropriately staffed.

The hospital had refurbished the post-natal wards facilities, which ensured the postnatal bays had more space for partners to stay overnight and the bathrooms were refurbished to modern standards.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each women/birthing person and take action to remove or minimise risks. Women and birthing people presenting in triage were not always prioritised according to their clinical needs. However, staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff did not always use guidance based on national guidance to assess and prioritise women and birthing people who attend the service and not all staff were clear about the process for referring women to triage, triaging women, and the criteria to categorise them depending on their clinical urgency. However, the service was in the process of implementing an evidence-based, standardised risk assessment tool for maternity triage in February 2023.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.

The service aimed for women and birthing people to have their first assessment within 15 minutes to risk assess and prioritise women to be seen first. The maternity triage waiting times review audit for September 2022 showed midwives reviewed 72% of women and birthing people within 15 minutes of arrival and 15% were reviewed within 30 minutes of arrival. The result also showed 12% of women were seen within an hour while 4% were seen after an hour.

Maternity

The service did not have protected midwifery staff to respond to and manage the triage telephone line. This was on the risk register and there was on-going consultation and restructure plans in place, which was due to be actioned in June 2023.

Staff knew about and dealt with any specific risk issues. However, staff did not always use the fresh eyes (helicopter view) approach to safely and effectively conduct fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The audit from July to November 2022 showed clear interpretation and management plans following CTG however staff did 'fresh eyes' at each hourly assessment in only 63% of cases.

For the period of August to September 2022, the reduced fetal movement audit showed an overall 99% compliance.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman or birthing person. From the patient records reviewed, we noted that staff correctly completed the MEOWS chart and had escalated concerns to senior staff. Staff completed a quarterly audit of 20 records to check they were fully completed and escalated appropriately. Audits for the period of November 2022 to January 2023 showed an overall 63.4% compliance on the 6 standards audited. The result showed that staff performed well on the completion of recording of observations (96%) however improvements were needed in the completion of fluid balance, height, weights, triggers, and documenting when a doctor was called. Senior staff told us actions plans were implemented following the audits and used to plan the regular teaching sessions.

Staff described how they would respond to a medical emergency or unplanned events, which was in line with the trust policy. Staff undertook regular skills and drills scenario training on a yearly basis. The maternity dashboard showed that 94% of staff had completed skills and drills in 2022, which was better than the trust target of 75%. We observed staff planned and respond appropriately to care for women and manage telephone queries in response to a planned ambulance strike during our inspection.

Women and birthing people who were at risk of gestational diabetes (high blood sugar that develops during pregnancy) were referred to the diabetic clinic for a glucose tolerance test to monitor and assess their blood sugar levels to prevent gestational diabetes, hyperglycaemia (high blood sugar) or hypoglycaemia (low blood sugar). The findings of these risk assessments were used to help women and birthing people choose their preferred place of birth and plan future care provision.

Women and birthing people were offered screening for infectious diseases, such as hepatitis B and syphilis. Women and birthing people were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, which was in line with national recommendations (NICE *Antenatal care for uncomplicated pregnancies: CG62,* updated January 2017). The antenatal handheld records we reviewed confirmed this.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Maternity

Staff shared key information to keep women and birthing people safe when handing over their care to others. The patient care record was kept on a secure electronic patient record system used by all staff involved in the women's care. Each episode of care was recorded by health professionals and was used to share information between care givers where required.

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver joined-up care to people who use services. This included joint perinatal clinics and joint working between the maternity and sickle cell and hematology team to care for women and birthing people with sickle cell disease.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection, we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe, was shared. Staff had a daily operational huddle and MDT safety huddle to review staffing and acuity and to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about the patients and an electronic handover board was also used in the meeting. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient.

Maternity staff collaborated jointly with several specialist teams such as the perinatal team and diabetic team.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

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

Staff completed risk assessments prior to discharging women and birthing people and pregnant people into the community and made sure third party organisations were informed of the discharge.

The service had two fail-safe officers in the screening team which ensured the safety of the screening pathway, and their roles were to identify when and where things are not working so that the service can improve them.

Midwifery Staffing

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

At the time of inspection, the service had 183 Midwives, 30 maternity support workers, 6 theatre nurses and 16 maternity admin staff in post within the maternity service. The January 2023 local birth rate plus report highlight that the service had a shortfall of staff of 6.23 (Whole Time Equivalent) when the current staffing establishment was compared against the May 2022 Birthrate plus recommendation. The report highlighted that although there was a deficit of 6.23WTE in staff establishment, there have been an increase in complexities of women seen in the service such as increase in induction rate, total of women seen aged 45 and above and significant increase in new to follow-up ratios. Based on the reduced birth rate and complexities seen in 2022 the staffing establishment was adequate to delivery safe care to women and babies.

Maternity

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. From 18 July 2022 to 26 December 2022 there were 46 red flag incidents.

Senior managers monitored staffing daily at the daily maternity situation report meetings.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The ward manager adjusted staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas and acuity.

During inspection we noted that the number of midwives and healthcare assistants matched the planned numbers.

The service had reducing vacancy and turnover rates. At the time of our inspection, the vacancy rate was 17% for midwifery staff. The service had recruitment and retention plans in place and recently recruited 10 international midwives that commenced in post the week before the inspection.

The sickness rate for nursing and midwifery staff in the division decreased from 11.2% in March 2022 to 5.8% in May 2022, before increasing to 7.4% in September 2022. This sickness rate was higher than the trust target of 3%.

Managers complimented staffing levels with bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. . There were maternity service orientation packs available to all staff including temporary staff to familiarise themselves with the service and its processes.

The service made sure staff were competent for their roles. Managers supported staff to develop through yearly, constructive appraisals of their work and held supervision meetings with them to provide support and development.

Data supplied by the trust during the inspection, showed appraisals completed for maternity staff was 97%. A practice development team supported midwives. The team included 7 practice development midwives and 3 of the midwives focused on recruitment and retention of staff.

Managers made sure staff received any specialist training for their role to enhance practice. For example, three midwives had received funding for specialist training including masters level courses in advanced midwifery practice, medical education training, future consultant leadership program, midwifery fellowship programme and the professional midwifery advocate course.

The service had a maternity workforce plan in place for 2022/23.

Maternity

The maternity service had not closed in 2022. However, there had been occasions when the birth centre and home birth teams had been suspended for few hours due to staffing, on-call staffing arrangements for the home birth team and/or low activity. The home birthing team was on the service's risk register due to lack of adequate on-call cover. Staff told us this had not impacted on patient care.

For the period of January to December 2022, 98% of women received one to one care during active labour against the trust target of 100%.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number.

Consultants were on site 8am to 9pm Mondays to Fridays and on-call 9pm to 8am, 7 days a week. Consultants were on site on weekends 8am to 4pm and 7.30pm to 9pm. The service always had a consultant on call during evenings and weekends. Managers could access locum doctors when they needed additional medical staff. Managers made sure locum doctors had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

Data supplied by the trust showed there were 18 (12.1 WTE) consultant obstetricians, 16 WTE consultant anaesthetists and 19 medical trainees which include registrars, senior house officer and GP trainees working in the maternity unit as of 23 January 2023.

The maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward. The service also had a dedicated senior house officer and GP trainees covering the triage with the support of an on-call registrar and consultant between 8am and 5pm. When there was high acuity in the afternoon and out of hours, an additional senior house officer and on-call gynaecology medical team were allocated to cover triage.

The service had low vacancy, turnover and sickness rates for medical staff. The service was recruiting two more consultant post as at the time of inspection to cover the on-call rota. Locums were used to cover gaps in rota.

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.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

The General Medical Council national training survey (GMC NTS) 2022 showed the service performed similar to national average on most indicators and better than national average on rota design and educational governance.

Records

Maternity

Records were clear, stored securely and easily available to all staff providing care. Although staff kept detailed records of women and birthing people's care and treatment however, not all records were up to date.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 8 paper records and found records were clear and saw evidence consent was obtained and recorded. The service had a consent sticker system in place to standardise the evidence documentation process of when consent had been completed for a women or birthing person. However, there were gaps in the documentation of mental health and safeguarding screening assessment.

Handheld notes were documented and given to the women. Women carried their own handheld pregnancy records, which staff completed and advised women to bring at each antenatal appointment and, on any occasion, when they attended the hospital. This was in line with the NICE Antenatal care for uncomplicated pregnancies guideline (2019).

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

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

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 5 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was any variation.

Staff learned from medicines safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers did not always ensure that actions from patient safety alerts were implemented and monitored. However, incidents were not always graded in line with national guidance.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. The November 2022 governance newsletter include the trigger list on the potential reportable incidents and near miss. From 1 January 2022 to 6 January 2023, the service reported 859 incidents, and these were mostly categorised as no harm (90.7%), low harm (7.6%) and moderate harm (1.5%). The incidents were mainly related to treatment, clinical assessment and access.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event

The service had no 'never' events on any wards in the last 12 months. Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents (SIs) clearly and in line with trust policy. From 1 January 2022 to 6 January 2023, the service reported 6 SIs in the service of which five met the criteria for referral to the Healthcare Safety Investigation Branch (HSIB) in line with national requirements. Four related to hypoxic-ischaemic encephalopathy (HIE) and/or baby cooling and one to intrapartum still births. HIE is a brain injury that occurs when the brain experience decreases in oxygen or blood flow. Most of the HSIB investigations did not include any recommendations but there were two recommendations related to clinical oversight and guidance.

Staff reported serious incidents clearly and in line with trust policy. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. Managers reviewed incidents potentially related to health inequalities.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Managers monitored the service compliance to the duty of candour. Staff felt they were good at listening to women and birthing people's concerns whilst not being defensive and had open conversations with women and birthing people when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service via emails, newsletters, safety huddles and learning from risk meetings.

Staff discussed the feedback and looked at improvements to the care of women and birthing people.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medicine incident. The service had also developed of trigger list guide for potential incident and near miss reporting such as post partum haemorrhage.

Managers debriefed and supported staff after any serious incident.

Staff involved in the investigation of incidents had completed appropriate training. This was an improvement from the last inspection.

Maternity

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good.

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

There was a clearly defined management and leadership structure. The maternity leadership team consisted of a clinical director, an obstetric lead, director of midwifery, interim director of operations and chief pharmacist. The maternity leadership team were supported daily by head of midwifery, matrons, ward managers, consultant midwife and specialist midwives.

Leaders were visible and approachable in the service for women and birthing people and staff. Staff told us they were well supported by their line managers, ward managers and matrons. They told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service leaders told us they had good direct access to the trust board, and this worked very well. We saw from the minutes of board meetings that the trust board had oversight of the maternity service and received presentations on the maternity service. The service was supported by maternity safety champions and non-executive directors.

Leaders and managers supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and professional development programmes such as quality improvement and advanced clinical practitioner midwife masters programmes to help all staff improve on their knowledge and practice.

Vision and Strategy

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

The service had a joint vision for what it wanted to achieve for the maternity and neonatal services and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Maternity

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity and neonatal service vision focused on coordinated continuous approach, ease of access and support to community. The vision also focused on choice for local women and birthing people, digitally enabled facilities, health promotion, positive physical environment, active birth centre and high digital maturity. The vision was underpinned by the divisions commitment to deliver the recommendation of the better birth report in line with the national maternity and neonatal transformation programme. The service strategy focused on culture, workforce development, continuity of care, estate and facilities, workforce compliance and a national maternity safety and assurance.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had revised the vision and strategy to include these recommendations.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

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

There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and speak highly of the culture. Staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. The culture was one of learning and focused on improvement, not blame. Staff were enthusiastic and passionate about their role and the difference they made to the experience of women and birthing people and their families.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with, clearly demonstrated this. Staff and women and birthing people spoke positively about how pleased they were that the continuity of care team continued to operate during the COVID pandemic to deliver safe and compassionate care to women and birthing people.

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

The service was committed to promoting equality and diversity and inclusion through its policies, procedures and practices. All policies and guidance had an equality and diversity statement, and staff told us they worked in a fair and inclusive environment. The maternity leadership team reflected diversity, particularly in terms of genders, cultures, ethnicities and skills to meet the patients holistic and cultural needs. The hospital had several staff equality and inclusion networks to support staff around equality, diversity and inclusion such as the "LGBTQ+", and ethnic and minority groups and WhitAbility' staff networks. The 'WhitAbility staff networks' focused on supporting staff with disability or interest in disability issues at work.

Maternity

The hospital launched the 'See ME First' staff-led initiative in October 2020 to promote equality, diversity and inclusion. This initiative highlighted that the organisation treated ethnic and minority groups with dignity and respect and was implemented as part of the trust commitment to having zero tolerance for any form of discrimination. The initiative also aimed to support staff who were subjected to such behaviour to speak up and challenge any abusive or discriminatory behaviour in a safe way.

The trust celebrated staff and team successes and supported good staff practice through a thank you initiative system, staff awards, Christmas party, etc.

Staff told us they supported each other and described the service as their 'second family' and a family and community orientated place. Medical staff including junior doctors spoke positively about feeling welcomed in the service as one of the consultants organised a regular welcome tea meeting for all new doctors to meet maternity unit staff. The service had set up a reverse mentoring programme which match senior to junior staff to help build an inclusive and diverse culture and improve staff relationships across teams. The service also set up a reciprocal multidisciplinary mentoring programme which matched medical staff to midwifery staff to help build and improve staff relationships and development across teams.

Several junior and senior staff had been working at the trust for years and staff felt that there were opportunities to progression and career development, and we saw evidence of this. The service had an open culture where women and birthing people, their families and staff felt comfortable to raise concerns without fear and retribution.

Women and birthing people, relatives, and carers knew how to make a complaint or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach possible to deal with complaints. Information about how to make a complaint was clearly displayed at the service to ensure women and birthing people and visitors had easy access to this information. Staff understood the policy on complaints and knew how to handle them.

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

The service had a clear policy for acknowledging complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, not all policies and guidelines were up to date.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a governance structure that supported the flow of information from frontline staff to senior managers. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from service performance. The service had a governance and risk team which supported staff and managers on managing the governance process and performance in the service.

Maternity

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings and reports. The governance meetings included service, divisional and trust board meetings such as the clinical effectiveness group meetings, maternity and neonatal transformation programme board and serious incidents executive approval group meetings.

Meeting agendas included discussion around all aspects of governance and oversight of the service such as performance data, audits and training, feedback, guidelines and research update. Governance meetings were well attended with full multidisciplinary attendance from the minutes reviewed, and actions were highlighted and reviewed at each meeting. Outcomes of governance meetings and service dashboards were shared with staff through emails, newsletters and posters.

Staff understood their role within the team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies and guidelines were reviewed every 3 years, with a tracker monitoring review date. We looked at 24 maternity policies and guidelines of which four were overdue for review including the Management of Pregnancy Related Sepsis policy/guidance which had been due for review since June 2018 and the 2015 (version 2) maternity triage guidelines was due for review since October 2018. Also, The Modified Early Obstetric Warning Score (MEOWS) For The Early Recognition Of The Severely Ill Obstetric Women (2015) Guideline was due for review since July 2018. We also noted that the ratification date for one policy was not consistent with the approval date.

The service had fully implemented the immediate and urgent actions recommendations from a recent national maternity report and ten safety actions recommended by the national maternity safety champions.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards in the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBBRACE) 2022 audit, CQC 2022 maternity survey and General Medical Council National Training Survey (GMC NTS) 2022. The service was fully compliant with the Clinical Negligence Scheme for Trusts (CNST). The 2022 maternity service dashboard showed that the service was meeting their target on induction rate, breastfeeding initiation rate, neonatal death and still birth rate. Managers and staff used the results to improve women and birthing people's outcomes.

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

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the

monthly risk assurance meeting. The leadership team took action to make change where risks were identified. The maternity service had a risk register which included 10 risks such as lack of dedicated bereavement room, estate, staffing, triage, information technology and home birth. The risk register included a risk category, status and description of the risk, severity and rating of the risk. The risk register also included the control measures in place, assurance actions to mitigate risks, any progress made and the risk approval status.

There were plans to cope with unexpected events. They had a detailed local business continuity plan. During inspection, we saw that the service leaders had plans to respond to the ambulance strike and ensured there were additional staff in place to manage the telephone lines and respond to women and birthing people queries and direct to appropriate services in the hospital, community or local services. Information around the ambulance strike and the service arrangements in place was displayed on the hospital website and maternity areas.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The trust had a 2021-2024 digital strategy which focused on digital infrastructure, digitally enabled workforce health care records, digitally connected patients and business intelligence and analytics. The strategy focused on using integrated community and hospital data to improve care for women and birthing people and babies. The service was working towards the maternity yellow notes to be digital for women and birthing people to access and investing on technology to support the continuity of carer teams.

The hospital had completed a global digital exemplar programme around information management and technology and recently introduced an electronic handover board in the maternity service. Staff spoke positively about the use of the electronic handovers and how it has helped improve patient care, access to patient information and communication among the multi-disciplinary team.

The information systems were integrated and secure**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

Maternity

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people. Innovative approaches were used to gather feedback from service-users, including people in different equality groups, and there was a demonstrated commitment to acting on feedback.

There was a strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. The service gathered and acted on people's views and experiences to shape and improve on the care and services provided. We saw evidence that service user feedback was sought to inform changes and improvements to service provision during and after the COVID-19 pandemic.

The service engaged with the community including women and birthing people and staff from ethnic and minority backgrounds to ensure their views and experiences were gathered to improve on the service delivery.

The service had a well-established Maternity Voices Partnership (MVP) who had an active role in shaping the local maternity services. The MVP worked with the maternity service to bridge any gaps with harder to reach communities. They had regular meetings in the community and used social media platforms to connect with women, raise awareness, and act as their advocate where required. The MVP launched and promoted a 'Kindness won't hurt' campaign in response to some partners showing aggression towards maternity staff; this was to help improve staff well-being.

The trust valued their partnership working with the MVP and engaged with them regularly to ensure they were involved in service planning and delivery. This included walk arounds, review and monitoring of national maternity recommendations and the maternity unit refurbishment estate project. The MVP had also been involved in the co-production of information leaflets for women and birthing peoplesuch as the non-pharmacological product (dilapan) for the induction of labour.

The MVP had also been involved in the interpreters on wheels initiative aimed at promoting communication for none-English speaking pregnant women and birthing people to improve their experience. However, it was also recognised that more could be done to improve on the continuity of care team. This team was responsible for supporting women to home birth and there was limited resources in the community to support women and birthing people make an informed choice.

Local and senior managers were visible on the wards, they have walk arounds, which provided patients and staff with the opportunity to express their views and opinions.

Leaders understood the needs of the local population. The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Managers engaged with staff through various staff meetings, forums, listening events, newsletters and had introduced 'The Ockenden Cafés, which include staff from multidisciplinary teams, the MVP and senior managers. For example, newsletters included information on staff recognition, achievements, improvement project, health awareness campaigns, training and development and recruitments. Various staff were also celebrated for their achievements including two midwives who completed a capital midwife ethnic minority fellowship programme. The fellowship programme was launched in December 2021 to support band 6 and 7 midwives from ethnic minority groups into leadership roles in response to a national report.

Maternity

Notice boards included information on compliments and complaints from people using the service. The board showed the service had recently received two compliments but no complaints from September to November 2022. We also saw a feedback board where feedback from women about the care and service received were displayed. Women were highly positive about the care received, staff interaction, continuity of care team, birth experience and alternative therapy they had received. Also, the service had freedom to speak up guardians and Schwartz rounds to engage with staff and encourage staff feedback.

The service engaged with key organisations including other NHS Trusts and local authorities and charities to improve on patient outcomes.

In response to national maternity safety reports and recommendations the service had introduced the breakfast or lunch 'Ockendon Cafe' for staff to share outcomes of the report and recommendations. The service had developed weekly weekday learning events for staff which took place as part of this initiative. Staff were able to attend virtually or in person in the morning or afternoon. Staff told us each session focused on different themes from the national maternity recommendations.

The CQC received feedback from over 220 women and birthing people during the inspection period. Most of the feedback was a combination of positive and negative feedback. Themes from the positive feedbacks include compassionate care and service received, emotional support, supportive staff, staff professionalism and friendliness. Themes from the negative feedbacks include communication, staff attitude and staffing levels.

Learning, continuous improvement and innovation

The leadership team encouraged continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

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

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

The service and staff have been involved in various quality improvement and research projects. This includes a QI project to develop of a new pathway for risk assessing and prescribing aspirin for women at risk of fetal growth restriction and pregnancy induced hypertensions.

The consultant midwife had developed a care outside of guidance guideline to support women seeking care or choices outside guidance. The guideline was being implemented the week we inspected. Staff told us this was in response to a recommendation from their regional maternity assurance visit.

The female genital mutilation (FGM) specialist midwife had received a gold award in August 2022 from the chief midwife officer.

Maternity

The hospital launched a new essential parent app in May 2022 which was co-designed with expectant mothers to support them at every stage of the pregnancy.

The trust was the first NHS trust in London to set up COVID vaccination hub for mothers in the maternity service. Staff spoke positively about this initiative as it provided women the opportunities to speak to the midwife and ask any questions or queries, they might have about the vaccine before been vaccinated.

Women were offered free complimentary reflexology and acupuncture in the maternity fetal medicine unit as part of the NHS care and treatment.

The hospital had a maternity transformation programme board which had oversight on the staff recruitment and development, compliance with national maternity standards, culture transformation and information technology.

We saw examples of how the hospital and maternity service had contributed to improving system working in the North Central London. For example, the chief nurse and director of allied health professionals had led on the start well review for maternity and early years in the region.

One of the consultants had collaborated with airline pilots to deliver human factors simulation training to staff during the COVID pandemic. Staff spoke positively about this and how it has helped improve patient safety and reduced incidents errors.

The service had active quality improvement projects to enhance care for women and birthing people who used the service such as interpreter on wheels and induction of labour (IOL) with dilapan (non-pharmacological IOL product). There was an active QI project on improving staff awareness and confidence for caring for women and birthing people attending the maternity who identify as LGBTQ+.

The consultant midwife had linked up with the Midwifery Unit Network (MUNET), which is a community of practice that aimed to promote and support the implementation and improvement of midwifery units in the UK and internationally.

The bereavement midwife had been shortlisted for the 2023 Mariposa bereavement midwife of the year award.

Outstanding practice

We found the following outstanding practice:

- The trust was the first NHS trust in London to set up COVID vaccination hub for mothers in the maternity service.
- The service was piloting the ‘Interpreter on wheels’ system, which was a digital tablet that connected to interpreting services and could provide telephone or video links to interpreters at the touch of a button.
- In response to national maternity safety reports and recommendations the service had introduced the breakfast or lunch ‘Ockendon Cafe’ for staff to share outcomes of the report and recommendations.
- The service and the maternity voice partnership (MVP) working together was exemplary, active, and engaged well with the service to drive improvement, service delivery, co-produce leaflets and involved in quality improvement projects.

Maternity

- The MVP in collaboration with the service also launched the 'Kindness won't hurt' campaign in response to some partners showing aggression towards maternity staff; this was to help improve staff experience and well-being.
- The maternity service offered free complimentary reflexology and acupuncture to women in the maternity fetal medicine unit as part of the NHS care and treatment.
- The service and hospital actively promoted equality and diversity through various initiatives such as the 'See me first initiative'.

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 medical staff are up to date with the maternity mandatory training modules. (Regulation 12(1)(2) (c))
- The trust must ensure that medical staff, maternity theatre and support workers staff were trained to safeguarding level 3. (Regulation 12 (2) (c))
- The trust must ensure that the service uses a systematic approach for risk assessing women attending triage. (Regulation 12(1)(2)(a) (b))

Action the trust SHOULD take to improve:

- The trust should ensure that staff complete patient records and risk assessments appropriately such as the Modified Early Obstetric Warning Score (MEOWS) and fresh eyes. Regulation 17(1)(2) (b) (c))
- The trust should ensure policies, guidelines and procedures are reviewed and follow national guidance. (Regulation 17 (1)(2)(a) (f))
- The trust should ensure an environmental risk assessment is carried in all maternity areas and emergency call bells are ligature free. (Regulation 12(1)(2) (a) (b))
- The trust should ensure there is a dedicated maternity triage line and staffing cover to ensure the safety of women. (Regulation 12(1)(2)(c) (Regulation18))
- The service should consider a more suitable environment for women who have had a baby loss, until the formal plan for the bereavement suite comes to fruition.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 4 other CQC inspectors and 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.

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
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment