

Imperial College Healthcare NHS Trust

# Queen Charlottes and Chelsea Hospital

## Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

### Ratings

Overall rating for this hospital

Good



Maternity and gynaecology

Good



Neonatal services

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Queen Charlotte's & Chelsea Hospital provides maternity and women's and children's services. The hospital is a tertiary referral maternity unit with a nationally renowned centre for foetal care and the largest neonatal intensive care unit in the country. It has a labour ward with two fully equipped operating theatres adjacent to high-dependency care facilities. These are two of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The other six core services that are not provided by this hospital are: accident and emergency; medical services; surgery; critical care; end of life; and outpatients. These services are covered in the separate reports for Charing Cross, Hammersmith and St Mary's hospitals.

The team included CQC inspectors and analysts, doctors, nurses, experts by experience and senior NHS managers. The inspection took place between 03 and 05 September 2014.

Overall, we rated this hospital as 'good'. We rated the hospital 'good' for effective, caring and responsive services and 'requires improvement' for being safety and well-led.

We rated maternity as 'good' and neonatal services as 'requires improvement'.

Our key findings were as follows:

### Safe:

- Incidents were reported and learning took place from major and moderate incidents. However, learning from near misses and minor incidents did not always take place.
- Nurse staffing levels were not in line with national guidance which impacted on care delivery.
- Safeguarding policies and procedures were in place and appropriate action was taken to safeguard babies.
- The neonatal mortality and morbidity meetings took place regularly but did not have representation from obstetrics or midwifery.

### Effective:

- Policies and procedures were based on national guidance. Care was delivered in line with best practice guidance.
- Staff participated in a range of local and national audits. Action was taken on audit findings to improve patient outcomes.
- New staff attended local induction programmes and there was an emphasis on staff development and continuing professional development.

### Caring:

- Staff were caring and treated mothers, babies and families with respect and dignity.
- The bereavement midwife was available to provide emotional support to mothers, their partners and staff.
- The neonatal unit had a consultant on duty for the week. Families expressed a view that this arrangement did not promote continuity. They felt that, for those babies who were in the unit for significant periods of time, a named consultant would be beneficial.

### Responsive:

- Capacity did not meet the demands for the service; this was due to high staffing vacancies in the neonatal unit resulting in cots being closed. In the maternity unit, midwife shortages meant that the service not always responsive to individual mother's needs, and this resulted in a task-based approach to providing care that was not focused on the woman and baby.
- Facilities were available for partners and parents to be resident.
- Concerns and informal complaints were addressed proactively, reducing the number of formal complaints received about the services. Action was taken in response to complaints and information was disseminated to staff.

# Summary of findings

## Well-led:

- There were governance structures in place, including local risk registers. However, action to address identified risks was not always taken in a timely manner.
- The units had a vision to improve their services. The new chief executive of the trust was visible and had already made a positive impact on staff morale by listening to their concerns and making them feel supported.
- Neonatal staff were engaged in leading and participating in national research programmes.

We saw areas of outstanding practice including:

The focus on participating in and leading national research projects, including the evaluation of magnetic resonance imaging to predict neurodevelopmental impairment in preterm infants.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Review the staffing levels and take action to ensure they are in line with national guidance.
- Review the capacity of the maternity and neonatal units to ensure the services meet demands.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.

In addition, the trust should:

- Review the current training matrix for statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust-wide records.
- Ensure that the risk management process within the neonatal division is suitably robust and fit for purpose to ensure risks are assessed, investigated and resolved in a timely manner.
- Explore how staff can learn from minor incidents and near misses to avoid similar incidents occurring.
- Consider the neonatal service having representation at board level.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Maternity and gynaecology

### Rating

Good



### Why have we given this rating?

At the time of our inspection, the risk of unsafe care because of inadequate midwifery staffing had been mitigated by prioritising the needs of women in labour. However, the quality of care on postnatal wards was sometimes compromised. The business case for additional staff had been accepted and recruitment to these posts was underway, but new members of staff had not yet commenced in post. Care was delivered based on national guidelines and evidence. The service had an audit programme to assess compliance with best practice. Staff at all levels felt able to raise concerns and these were addressed. There was an embedded multidisciplinary approach to learning from incidents and complaints.

Specialist clinics assessed the needs of women with medical conditions and their care was provided by specialist and caseload midwives (a midwife who delivers one-to-one care for an agreed number of women). Women were encouraged to make a choice about the type of birth that was best for them and their babies. The community midwifery service provided local women with continuity of care.

There was a range of training and professional development opportunities for midwifery staff and trainee doctors. Staff were positive about their contribution to improving the quality of care and felt their efforts were recognised and valued.

#### Neonatal services

### Requires improvement



The national shortage of specialist neonatal intensive care trained nurses was impacting on the ability of the neonatal intensive care unit (NICU) to function at its full 42-cot capacity. A shortage of nurses had resulted in the department only being able to staff 24 cots. The division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided.

Parents were mostly complimentary about the care and treatment, although they felt there could be improvements and consistency with

# Summary of findings

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communication among the consultant group. Parents felt that staff across all disciplines were compassionate, understanding and caring. Where parents/carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future.

The senior management team were cohesive and it was apparent that all those working in this division were passionate about influencing the care and treatment of neonates (new-born infants). However, there had been a lack of progress in addressing the risks identified in the division. Some risks had been with the management team for over five years; there was little or no evidence to demonstrate that these risks were being addressed in an effective way.

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Good 

# Queen Charlottes and Chelsea Hospital

## Detailed findings

### Services we looked at

Maternity and family planning; and Neonatal services

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# Detailed findings

## Background to Queen Charlottes and Chelsea Hospital

Queen Charlotte's & Chelsea Hospital provides maternity and women's and children's services. The hospital is a tertiary referral maternity unit with a nationally renowned centre for foetal care and the largest neonatal intensive care unit (NICU) in the country. It has a labour ward with two fully equipped operating theatres adjacent to high-dependency care facilities.

It is one of five of Imperial College Healthcare NHS Trust locations. The trust also provides services from Hammersmith Hospital, Charing Cross Hospital, St Mary's Hospital and the Western Eye Hospital.

Queen Charlotte's & Chelsea Hospital has 127 beds: 72 are maternity beds and 55 are neonatal intensive care cots.

The chief executive officer and medical director were both appointed to the trust board in the last 12 months.

## Our inspection team

Our inspection team was led by:

**Chair:** Peter Wilde, Consultant MRCP, FRCR

**Head of Hospital Inspections:** Heidi Smoult, Care Quality Commission

The team of 35 included CQC inspectors and analysts and a variety of specialists: consultants in emergency

medicine, medical services, gynaecology and obstetrics, palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses' a student nurse; and experts by experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following services at the Queen Charlotte's & Chelsea Hospital :

- Maternity and family planning
- Neonatal services.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical

commissioning group; Monitor, Health Education England; General Medical Council (GMC); Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in White City, London on 3 September 2014, when people shared their views and experiences of the Imperial College Healthcare NHS Trust.

We carried out an announced inspection visit on 3 and 4 September 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, dietician, physiotherapists and pharmacists.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the

# Detailed findings

outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed patients' personal care or treatment records.

## Facts and data about Queen Charlottes and Chelsea Hospital

Queen Charlotte's & Chelsea Hospital has maternity, women's and children's services, with a tertiary referral maternity unit and a large NICU. The labour ward has two operating theatres and high-dependency care facilities, and there is a midwife-led birth centre. The West London Gynaecology Cancer Centre is also based at the hospital.

### Context

- Around 127 beds
- Employs around 596 whole time equivalent (WTE) members of staff.

### Activity

- Around 5,000 births per annum
- Around 444 neonatal admissions

### Key Intelligence Indicators

#### Safety

- No Never Events (serious safety incidents that should not occur if proper preventative measures are taken) in the last 12 months.

#### Inspection history

One previous inspection in 13 December 2012 prior to the publication of ratings.



# Detailed findings







## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Neonatal services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Good

### Notes

# Maternity and gynaecology

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Queen Charlotte's & Chelsea Hospital provides a range of maternity services: community midwifery services delivering antenatal and postnatal care for women in the area; a midwifery-led birth centre; antenatal clinics; an early pregnancy assessment unit; a triage service; a day assessment centre; labour suite; antenatal and postnatal wards; and obstetric theatres. Queen Charlotte's & Chelsea Hospital is a tertiary referral centre and has a level one neonatal intensive care unit (NICU), and manages a centre for foetal and maternal medicine for women with complex needs. There is also a consultant-led service for private patients. There were around 5,000 births in 2013. Maternity services are part of the trust's women's and children's division. During our inspection, we spoke with 10 women who used the service and 28 staff, including maternity support workers, midwives, doctors, consultants, administrators and senior managers. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We inspected the areas where maternity services were provided, looked at care records, and reviewed information provided by the trust, such as audit and performance data.

## Summary of findings

At the time of our inspection, the risk of unsafe care because of inadequate midwifery staffing had been mitigated by prioritising the needs of women in labour. However, the quality of care on postnatal wards was sometimes compromised. The business case for additional staff had been accepted and recruitment to these posts was underway but new members of staff had not yet commenced in post.

Care was delivered based on national guidelines and evidence. The service had an audit programme to assess compliance with best practice. Staff at all levels felt able to raise concerns and these were addressed. There was an embedded multidisciplinary approach to learning from incidents and complaints.

Specialist clinics assessed the needs of women with medical conditions and care to these mothers was provided by specialist and caseload midwives (midwives who deliver one-to-one care for an agreed number of women). Women were encouraged to make a choice about the type of birth that was best for them and their babies. The community midwifery service provided local women with continuity of care.

There was a range of training and professional development opportunities for midwifery staff and trainee doctors. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good



The process for learning from incidents was embedded. The staff we spoke with said they felt able to raise concerns and that these would be addressed. There were effective processes in place to safeguard women and babies against the risk of abuse. There were high rates of completion of mandatory training for midwifery and maternity support staff.

There were inadequate midwifery staffing levels at the time of our inspection, but action had been taken to mitigate the risks to mothers and babies. This action included using bank and agency staff and relocating staff to the labour ward. The recently revised escalation policy provided staff with clear instructions to follow when demand was high. The business case for increased staffing had been agreed and additional midwives and midwifery support workers had been recently appointed but had not yet commenced in post.

### Incidents

- Midwifery staff and trainee doctors said they were able to voice concerns by talking to more senior staff and/or by recording them on the incident reporting system. They told us about action that had been taken to address concerns.
- The risk midwife and the obstetric lead for risk worked together to investigate serious incidents, to support senior staff in investigating other incidents and to analyse trends. We were told that incident reporting had increased and staff were encouraged to report staff shortages when this had an impact on care.
- We found there was an open culture with an emphasis on learning without 'pointing the finger'. When there had been no harm to women or their babies, incidents which had been 'near misses' were used for discussion and learning.
- Staff of all grades said there was a focus on learning from incidents and learning from incidents and complaints was disseminated. All staff were invited to the monthly critical review meeting of serious incidents. Executive summaries of recently completed serious incident investigations were available on the intranet.

Midwives told us the Risky Business newsletter included learning from recent serious incidents and actions arising from complaints. We saw that this was the case in the most recent issue of this newsletter.

- The maternity incident reports included action that had been taken to reduce the likelihood of a recurrence of similar incidents. An example was a delay in transfer to theatre for an emergency caesarean section. Action taken included the senior trainee doctor having discussions with a consultant, the midwife working with the supervisor of midwives on an audit of all notes, and dissemination of learning in the Risky Business newsletter.
- There was a monthly, cross-site perinatal mortality meeting attended by consultants and midwives from maternity services, a pathologist and a neonatologist to discuss contributory factors and identify any learning.

### Midwifery staffing

- Inadequate midwifery staffing levels had been recognised as the principal risk for the service and a contributing factor in poor outcomes in the previous year, such as unexpected admissions of babies to the NICU. At the time of our inspection, the ratio of one midwife to 33 women was lower than the national average of one to 29.
- Midwifery and maternity support staff of all grades told us there were staff shortages at times. This had been particularly acute over the summer months when it had been difficult to fill vacant shifts with bank staff. One-to-one care during established labour was prioritised by bringing in additional staff to the labour ward, but maternity staff told us it had not been possible to provide one-to-one care at all times during the previous year.
- Ward coordinators were instructed to escalate matters to the senior midwife in working hours, or to the site nurse practitioner out of hours, when staffing levels were below the planned level and staff judged that this prevented safe care. Staff told us of various actions that had been taken to address shortages, including redeploying midwifery staff to the labour ward from other wards to ensure one-to-one care during established labour, requesting community midwives, practice development midwives or risk midwives to work on the wards, cancelling non-clinical activity such as training, and delaying inductions of labour and elective caesarean sections. The unit had also refused

# Maternity and gynaecology

admission to some in-utero transfers that required tertiary care because of insufficient staffing on the labour suite. When there was an 'amber alert', the consultant obstetrician and the coordinator on the labour suite worked together to prioritise workload according to clinical need.

- The recommended ratio on postnatal wards was one midwife to six women, but we were told this had frequently been higher during the summer months and staffing had been below the staff establishment of five midwives and two midwifery support workers.
- To mitigate the risks posed by midwifery staffing shortages, there was a monthly establishment review meeting to look at staffing levels, and a weekly meeting with the agency providing bank and agency staff to identify any shifts that had not been filled. An additional bank midwife was sometimes rostered on duty in advance, and stood down if capacity met demand. The use of agency staff was authorised 48 hours prior to any possible shortfall.
- A business case to improve the midwifery ratio to one midwife to 30 women by 2015, which is just higher than the national average, had been agreed by the trust and the first phase of the plan had been implemented, with the recruitment of midwives, maternity support workers and scrub nurses (operating room or perioperative nurses), who would begin working from October 2014. There was further recruitment planned for 2015.

## Medical staffing

- There was 98 hours of consultant presence on the labour ward, in line with recommended practice for a unit of up to 5,000 births a year. However, this recommendation does not take into account acuity, the intensity of patient care needed, which was higher on this unit than the average maternity unit. A consultant was available on call at other times.
- Anaesthetic consultant support and/or on-call availability was in place 24 hours a day, in line with national recommended practice.

## Safety thermometer

- The NHS Safety Thermometer, a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care) had been adapted for use in the maternity services and audits were undertaken monthly. The results were displayed on the wards and showed that there had been harm-free care on maternity wards in recent months.

## Cleanliness, infection control and hygiene

- There were regular trust-wide audits of infection control and the World Health Organization (WHO) 'Five Moments for Hand Hygiene' in each ward monthly, with a reported compliance rate of over 98%.
- The trust was conducting a rolling programme of training in the aseptic non-touch technique competency.
- We observed staff using personal protection equipment, such as gloves and aprons. Hand gel was available at the entrance to, and within, the clinical areas.
- Midwifery staff were aware of cleaning and infection procedures for birthing pools and of the recent safety alert describing the procedures to follow when using a birthing pool.
- The fridges storing blood, expressed breast milk and food were clean and the temperature checks regularly completed.

## Environment and equipment

- The adult and neonatal resuscitation equipment in the wards and in the birth centre were clean and regularly checked.

## Records

- We observed that women visiting the clinics had access to their hand-held records, the 'red book'.
- The introduction of the new electronic record-keeping software at the trust had resulted in problems with booking antenatal and postnatal appointments and in keeping records up to date. Staff told us these problems were becoming less frequent and there had been additional training to help reduce problems. The community midwifery team had encountered particular problems and additional resources had been allocated to address these. A team made daily data quality checks and reported weekly on progress.
- We were told that administrative staff had difficulty accessing the medical records library because of limited access times. In addition, manual notes were sometimes taken out by medical and midwifery staff without booking. There was reduced administrative staffing to deal with these difficulties.

# Maternity and gynaecology

## **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Consent was part of mandatory training for midwifery and obstetric staff. Women who might lack capacity were identified early in the pregnancy and supported by caseload midwives.

## **Safeguarding**

- There were processes to safeguard unborn and newborn babies and caseload midwives provided care and support to women who were considered high risk. There was a cross-site midwifery lead for safeguarding who monitored safeguarding cases. There had been a recent initiative involving the obstetric lead for mental health and the perinatal psychiatrist to improve antenatal assessment to identify women at risk because of mental health needs. The midwifery staff with responsibility for safeguarding had good contacts with the local authority child protection staff, GPs and other health professionals in the community and attended case conferences. Maternity services had requested a safeguarding page on the new electronic patient record system and this has resulted in improved information-sharing about women and babies at risk.
- Midwifery staff attended Safeguarding level 2 or 3 as part of their annual mandatory training. We noted that midwives were aware of indications that a mother or baby might be at risk.
- Women who had been subject to female genital mutilation were assessed to establish the risk to their female children.
- Electronic tags were available in the labour ward to be worn by babies for whom there was a safeguarding concern. Sensors in the tags caused alarms to sound and doors to seal if the tagged baby was detected near one of the exits.
- Following an incident when there were concerns that a mother might try to abscond with her baby, we saw that the safeguarding midwife had arranged to meet with the trust security team and relevant agencies to discuss precautionary measures to avoid a recurrence in the future.
- Midwives contacted the safeguarding lead and the maternity independent domestic violence specialist for advice when a woman disclosed that she had been abused. Midwives were receiving training to identify vulnerable pregnant women.

- Women whose babies were subject to protection orders are known to be at high risk of self-harm and so the safeguarding lead was setting up a support group for these women.

## **Mandatory training**

- There were mandatory education programmes for midwives and for maternity support workers, in addition to the annual statutory mandatory training day for maternity staff. The completion rate for midwifery staff was 90% for mandatory training in 2013. The figure for maternity support was 86.6%.
- A practice development midwife told us the comprehensive training meant that midwifery staff felt adequately prepared to be flexible in response to high demand, for example, when community midwives were called into the maternity wards to meet patient demand.
- There was announced and unannounced 'skills drills' training to rehearse obstetric emergencies.

## **Assessing and responding to patient risk**

- Midwives and trainee doctors said they felt able to discuss any concerns they had about the progress of labour with more senior staff, and would have no hesitation in calling a consultant out of hours if they needed their advice or presence.
- Mandatory training for midwifery support workers included recognising ill women, using the modified early obstetric warning score.
- There were two dedicated high dependency unit (HDU) beds for women needing additional postnatal care. Staff working on the unit received training in looking after ill patients, and a local audit had found appropriate documentation of observations.
- Local audits found 100% compliance with assessment of risk of venous thromboembolism (VTE or blood clots) antenatally, on admission and post-delivery.
- We were informed of the recent reinforcement of the role of anaesthetists and surgeons in leading the three steps of the WHO surgical safety checklist in obstetric procedures. The surgeon was expected to lead sign-out, and to promote debriefing and learning. The recent trust observational audit of the use of the checklist had found 98% compliance with the sign-in step and 100% compliance with the time-out and sign-out steps of the checklist in obstetric theatres.

# Maternity and gynaecology

## Major incident awareness and training

- The maternity staffing escalation policy had recently been simplified to clarify the responsibility of staff at all levels when there was a risk of staff shortages having an impact on safety. An 'amber rating' was initiated when midwives were not able to provide one-to-one care to women or there was a risk of beds not being available to women coming to, or transferring from, the labour ward. When the unit was full or staffing levels were inadequate to provide safe care, this was escalated to a 'red rating', the head of midwifery was informed and actions taken, including the closure of the unit if necessary.

## Are maternity and gynaecology services effective?

Good



There was evidence of learning in maternity services and national guidance was reviewed and disseminated. There was a coordinated audit programme to assess compliance with best practice and multidisciplinary meetings to discuss the results of these audits. Outcomes for women and their babies were within expected limits. However, the care for women and babies on the postnatal ward in the immediate post-labour period was not always in line with best practice because of midwifery staff shortages. The newly established community midwifery service was providing effective antenatal and postnatal care in facilities near their homes.

There was a training programme for midwifery staff and all staff had opportunities for professional development. Trainee doctors were well-supported.

## Evidence-based care and treatment

- Policies, protocols and guidance were based on national guidelines and standards. New guidelines were reviewed and disseminated.
- There was a trust process for discarding out-of-date guidelines, which had been fully implemented in the women's and children's division.
- There was a local audit programme, coordinated by obstetricians with responsibility for education, with results presented at a cross-site, multidisciplinary meeting. We saw information about these audits and noted that action from previous audits had been

identified and monitored, and there was evidence of improvements as a result. Recent audits included the assessment and care of women having multiple births, and the documentation of induction of labour.

- The maternal and foetal medical centre provides evidenced-based care for pregnant women with medical conditions in specialities such as endocrine, cardiovascular and haematology.
- The maternity service was working towards UNICEF's Baby Friendly Initiative status.
- The reconfiguration of community midwifery services provided continuity of support in the antenatal and postnatal periods for local women, in facilities close to their homes, in line with best practice.

## Pain relief

- The full range of pain relief was available to meet the individual needs and preferences of women. These included epidural analgesia, opiates and nitrous oxide (gas and air), paracetamol and the use of water in birthing pools.

## Nutrition and hydration

- 90% of women who gave birth at Queen Charlotte's & Chelsea Hospital in 2013 were breastfeeding their babies when they were discharged which is higher than the national average.

## Patient outcomes

- The hospital provided care for women with medical conditions, those with hypertension during pregnancy and women with placenta previa/accreta. There was also a higher-than-average percentage of women who were over 40 years and who were having multiple births cared for. Local audits of the medical records of high-risk groups of women found that appropriate care had been provided throughout the pregnancy.
- The caesarean section rate was 25% in 2013, which is in line with the national average, in spite of the higher acuity levels of women using the service than in the average maternity unit.
- Midwifery staff of all grades told us that staff shortages on the postnatal ward had been detrimental to the care of women and children. Midwifery staff told us they prioritised babies requiring additional and transitional care, but we noted there had been incident reports of late doses of intravenous antibiotics. Midwifery staff who worked on the ward told us it was difficult to

# Maternity and gynaecology

provide the support women needed, such as assisting with breastfeeding, and they felt this might have an impact on how confident women felt looking after their babies.

- The number of neonatal and maternal readmissions to hospital were in line with expected rates.
- The vaccine to protect babies against tuberculosis was offered to 99% of families.

## Competent staff

- There was an induction programme for new midwifery staff, which was being further developed by the practice development midwife responsible for recruitment. All new staff were assessed for basic competencies before they were allowed to work.
- Recently qualified midwives had benefited from a structured preceptorship practical experience and training programme. One of these midwives said her programme was going “brilliantly”. She saw her mentor regularly and was able to access advice easily. We observed that a practice development midwife was supporting a new member of staff in a clinical area which was very busy to ensure they felt supported in their new role.
- The training programme for midwives and midwifery support workers was delivered by a mixture of workshops, on-the-floor training – for example, in the use of equipment – e-learning and assessment, which enhanced the safety and effectiveness of the care provided to women and their babies. There was an annual assessment of midwives’ competence in interpreting cardiotocograms (CTGs) when monitoring the baby’s heart rate and midwives who failed the assessment were not permitted to interpret CTGs on their own. Training had been adapted in response to the results of these assessments and the pass rate had improved.
- Midwifery staff told us that, in recent months, staff had sometimes been unable to attend training because they had been asked to work on the wards to cover staff shortages.
- The midwives working for the new community midwifery service told us they had been prepared for their new role through a bespoke training programme, which included a clinical decision-making day, a home-birth study day and team-building sessions.
- The training programme was changed regularly in response to new guidelines and expectations. The

programme now included an additional breastfeeding training day as part of the Baby Friendly Initiative. There was a training programme, developed with pharmacy and paediatric staff, for midwives providing antibiotics for babies requiring special care on the postnatal ward (transitional care).

- Midwifery support workers and midwives told us the training provided was “excellent”. They said they had discussed further opportunities for learning and development at their annual appraisals. Appraisal rate was over 90%.
- Midwives told us that the service prioritised continual professional development, and they were well-supported by practice development midwives and supervisors of midwives. The ratio of supervisors to midwives was one to 15, meeting good practice standards. We were told that supervision was structured and midwives knew who to go to for support.
- Trainee doctors said they received support from consultants, who were always available if they needed advice. Teaching was prioritised by the trust and the service, and we saw evidence of regular teaching sessions and an audit programme. Consultants used pagers to enable specialist trainees to attend training. The results of the General Medical Council (GMC) survey of trainee doctors found that junior doctors did not have concerns about the way they were supported. There had been a negative response from trainee GPs working in maternity services in the past, and action was taken to address the concerns.
- Obstetric consultants in the maternity service had produced a booklet for trainee doctors about understanding serious incidents, which was to be used throughout the trust and had been taken up for wider distribution by the London deanery.

## Multidisciplinary working

- Midwives and doctors told us there was good multidisciplinary communication. A midwifery support worker told us that there was good team work and everyone pulled together to provide good care for the women on the wards. A senior midwife told us that midwifery support workers and midwives “challenge and stand up for what they believe in”.
- Handover on the labour ward was not multidisciplinary, and paediatric staff did not routinely take part in handover discussions. We were told that, after the midwives handed over to the next shift in the labour

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ward, the consultant and/or other medical staff conducted a labour ward round and discussed each of the women with the allocated midwife. When there were indications that obstetric input might be required, medical staff would then talk to the patient. Midwives and trainee doctors told us this system was effective in understanding the needs of the women on the labour ward.

- The service was currently piloting a tool for use by midwifery staff to pass information to medical staff in a structured way.
- We were told there was effective working with paediatric staff, who were informed when they should attend a birth and responded rapidly when needed in an emergency. There were discussions with neonatal nurses about enhancing the care of babies needing transitional care on the postnatal ward.
- The new community midwifery teams worked closely with other health professionals in the community to support mothers and their babies.
- The maternity service had introduced a code of practice for commercial companies, for example, sales representatives who visit postnatal wards offering women and families information to ensure that women would not be asked for personal information without a full explanation of how this would be used.

## Are maternity and gynaecology services caring?

Good



Women we spoke with said they had received good care. They said they were involved in making decisions about the birth. Bereaved parents were supported.

### Compassionate care

- Three women we spoke with were very positive about having a named community midwife. One of them said the midwife had been “good at listening and respectful”.
- The results of the CQC 2013 Survey of Women’s Experiences of Maternity Care for Imperial College Healthcare NHS trust were similar to other trusts for most measures, such as being given appropriate advice and support when contacting a midwife, and being

- involved in decisions about labour. The results were lower than average for the length of time patients waited for a response to the call button. The results for involving partners were higher than average.
- The response rate to the NHS Friends and Family Test at the trust was higher than the average. There had been a dip in the birth and postnatal scores in January and February 2014, but these had risen to close to the average for England following this fall.

### Patient understanding and involvement

- Women who were seeing a named community midwife discussed their birth plans and had a choice about where to have their babies. They said the midwife took time to discuss things with them and develop a birth plan, and this made them feel confident about the birth. Another local woman felt she had missed out on talking to a midwife because she had been under consultant care. She said the doctors in the consultant clinic had been excellent, “but they don’t talk about things like a birth plan”.
- Two women, one who attended an antenatal clinic and one who attended the early pregnancy advisory unit, said they had found the doctors they had seen showed a lack of awareness of how anxious they might be. One of them said that two doctors had talked to each other about her and ignored her. They said that, apart from these experiences, staff had been kind and respectful.
- A woman, who had telephoned the triage service (the team that prioritised patients’ treatment), praised the efficiency of maternity services. She said she had been invited to come in right away and did not have to wait long to see a midwife and doctor.

### Emotional support

- A bereavement midwife was available to women who had lost a baby; they were also available out-of-hours if needed. The bereavement midwife also gave training to other midwives in helping families who had lost a child.
- When the birth did not proceed as expected, the consultant talked to the women and their partners during postnatal ward rounds to explain what had happened. The consultant invited them to return if they had further questions.

## Are maternity and gynaecology services responsive?



# Maternity and gynaecology

Good



The community midwifery service provided local women with continuity of care and supported women following the birth with services provided in the local children's centre or GP surgery. Specialist and caseload midwives supported women with specific individual needs, such as mental health needs.

Women with specialist medical needs attended an antenatal clinic to see an appropriate specialist. Women could contact the triage service at any time if they were concerned about their pregnancy. They were given an appointment at the day assessment centre if required. Postnatal wards were sometimes short-staffed and it was difficult to provide a responsive service that met individual needs.

## Service planning and delivery to meet the needs of local people

- The service had difficulty meeting demand and had presented a business case for increasing staffing levels, which had been accepted by the trust.
- We found there was an understanding of the needs of the local population as well as for women who were referred from outside the area for specialist care.
- The maternity service liaison committees had been consulted about reorganisation of the divisions within the trust. The committee had not been active recently because of changes in membership, but there were plans to bring in new members.
- Staff said that the facilities at the hospital met women's needs. The wards were spacious and well-decorated.

## Access and flow

- Women in the local area could self-refer by telephone or by completing a form on the hospital's website. Referrals were also made by GPs and other health professionals.
- 89% of bookings for antenatal care in 2013 were made before the twelfth week of pregnancy.
- There had been problems with antenatal bookings since the new electronic record-keeping system had been introduced at the trust. This had resulted in some appointments not being made and delays when women attended antenatal clinics. We saw that steps had been

taken to address these problems, and when we visited the antenatal clinic we saw that delays had been reduced. There were signs telling women of expected waiting times.

- The new community midwifery practices based at children's centres or GP surgeries made access easier for local women. The service promoting continuity of care and support for antenatal and postnatal care by allocating a named midwife for women in the local area. A midwife was rostered on at weekends for essential visits. Community midwives we spoke with said the referral routes worked well when they needed to refer to specialist midwives or clinics. They said they could contact an obstetrician for advice and refer women to the day unit. Some women preferred to go to antenatal clinics at the hospital and their preference was respected.
- Women from outside the area who were referred for specialist care were given a number to call if they had any concerns during pregnancy. Because they were attending a consultant-led clinic they might not be accessing midwifery services in their area.
- The early pregnancy unit provided a scanning service and consultant appointments in the mornings.
- The introduction of the triage service had reduced the pressures on the labour suite. Staff at triage had options for referring women on, such as making an appointment at the day assessment unit or sending the woman to the labour suite if labour was established. The service might find it helpful to note that a woman told us the triage service was not easy to find and that the signage was not clear.
- There were two dedicated theatres available 24 hours a day and a dedicated theatre team.
- Bed occupancy in maternity services at the trust had been lower than the national average of 58% in 2013; this had risen to the national average in 2014.
- We observed a postnatal discharge talk to a group of mothers and partners on the postnatal ward. A physiotherapist talked about postnatal self-care and exercises and midwives showed a film about looking after babies. All women were given printed information and advice to take home. There was an emphasis on actions to take if women were concerned about their baby and which hospital to go to if they needed urgent care, as the local Hammersmith Hospital A&E was due to close the week following the meeting.

# Maternity and gynaecology

## Discharge planning

- Patient discharge was sometimes delayed when there were midwifery staff shortages on the postnatal ward.

## Meeting people's individual needs

- There was a full range of maternity services and women were encouraged to make a choice that was best for them and their babies. The home birth service was available to a small number of women, and there were plans to expand this service.
- There was a dedicated midwifery-led birth centre, available to women with low-risk pregnancies, which had a non-clinical environment and always provided one-to-one midwifery care during labour. Women were seen at the centre in the last weeks of pregnancy.
- Women on the labour ward had the choice of a water birth. There were initiatives to facilitate vaginal births for women with high-risk pregnancies, and a consultant midwife met with women who wanted to give birth outside guidelines.
- Interpreting services were available at the hospital and staff told us they also used the telephone interpreting service.
- The community midwifery practices were working with health visitors to provide child-centred care. There was breastfeeding support and drop-in sessions for women to ask for advice. Parent education classes had interpreters present, including at the weekend. There had been very positive feedback about these classes.
- There were specialist midwives for safeguarding, HIV and infectious diseases, and for women who had undergone female genital mutilation. Caseload midwives in the community midwifery teams provided one-to-one support for women at risk, for example, because they had a learning disability or mental health needs.
- All the women we spoke with on the postnatal ward said they had been well looked after. However, midwives and maternity support workers told us how difficult it was at times to provide a responsive service that met individual needs. We observed that there was a task-focused approach to providing care, which meant that all the necessary tasks were completed, but care was not focused on the woman and baby.
- There were facilities for partners, who were allowed to stay on the ward out of hours.

## Learning from complaints and concerns

- We saw that action had been taken in response to complaints and information were disseminated to staff through the Risky Business newsletter.
- Staff told us they tried to address concerns early and provide an explanation and this had resulted in reduced complaints. There was information on the ward about raising concerns and staff told us they explained the complaints procedure to women or their families when they were dissatisfied with the care.

## Are maternity and gynaecology services well-led?

Good



Leadership was evident in the changes to the service, such as the introduction of community midwifery practices. Governance structures were in place and risks assessed. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued.

## Vision and strategy for this service

- The changes in the women's and children's directorate as a result of the trust restructure had been implemented effectively.
- We were told that the new chief executive of the trust had already made a positive difference to morale by listening to the concerns of frontline staff. The director of nursing was also visible and reported to be approachable.
- The introduction of the community midwifery practices had been a key element in the strategy for the service. The thorough planning and incremental implementation of the seven practices was presided over by staff working in the area. We found enthusiasm for its development and saw an enhanced focus on women's and children's individual needs.
- The business case made to the board for increased staffing had been successful. The case looked at the deployment of staff across all areas, including theatres, and examined the skills mix as well as number of staff.

## Governance, risk management and quality measurement

- Risks to the delivery of high-quality care in maternity services were analysed and controls put in place. Key

# Maternity and gynaecology

risks and actions were reported through the division's governance structure. The new executive team had introduced improved governance structures to assess and address risk at trust level.

- There was evidence that maternity services had processes in place to promote evidenced-based care, and to learn from incidents and complaints.
- Maternity services used a dashboard to monitor the safety and responsiveness of the service.

## Culture within the service

- We found a positive culture and optimism for the future in maternity services. Staff of all grades and roles felt a sense of responsibility for the quality of the service, and were also clear about when they should escalate concerns. A newly qualified midwife said "everyone has been supportive, no-one has made me feel bad if I need help to do something". A senior member of staff commented, "this is a learning trust, people are really encouraged to ask questions and get the evidence to make things better".
- Staff told us they felt valued by senior management and able to make a contribution to the development of services. Staff performance was recognised, and celebrated.
- The caseload midwifery team for vulnerable women had received the Royal College of Midwives team of the year award in 2014 and the head of the community midwifery service had received the MAMA Midwife of the Year 2014 award for helping women to have the birth of their choice.

## Leadership of the service

- Staff with a variety of roles and grades, including administrative staff, reported that leadership in maternity services had markedly improved in the last two years.
- Midwifery staff told us they were supported by their ward managers and said that management at all levels were approachable and there was an 'open door' policy.
- 'Back to floor Friday' had been introduced at the trust by the director of midwifery and nursing for women's and children's services, and subsequently rolled out to other parts of the trust. While we were at the trust we saw the director, the head of midwifery and matrons in clinical areas assisting staff. Senior managers also ran drop-in sessions on Fridays and told us of some of the suggestions that junior staff had made at these sessions, which had been implemented.
- We heard that some staff did not feel that they were treated equally when poor performance was identified.







## Public and staff engagement

- Action had been taken in response to comments from women and their families about their experience on postnatal wards, which had resulted in changes being made and improved patient feedback.

## Innovation, improvement and sustainability

- A project team consisting of ward staff of all roles and grades set out an improvement plan to support staff to embed changes in practice in the wards. There was an emphasis on valuing staff and creating a positive working environment, with a 'staff member of the month' nominated by women on the ward.

# Neonatal services

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

Queen Charlotte's & Chelsea Hospital provides level 3 neonatal intensive care unit (NICU) care to pre-term babies and babies born with complex medical needs. The NICU at Queen Charlotte's has a sister department in the Winnicott Baby Unit at St Mary's Hospital, part of the Imperial College Healthcare NHS Trust. The NICU is a leading centre for neonatal cooling, therapeutic hypothermia, in the North West London Neonatal Network. The unit accepted 24 neonates who required cooling as part of the hypoxic ischemic encephalopathy treatment pathway from external trusts; during 2013/14 a total of 43 neonates received cooling therapy.

Between April 2013 and March 2014 the NICU admitted a total of 444 neonates, the majority of which were born at Queen Charlotte's & Chelsea Hospital. The total number of care days for 2013/14 totalled 2,917 for babies requiring intensive care, 1,580 days for babies requiring high dependency and 2,581 for babies requiring special care.

We spoke with four parents, 10 members of staff, including nurses, matrons, junior doctors, consultants and support staff. We observed care and treatment being provided.

## Summary of findings

The national shortage of specialist neonatal intensive care trained nurses was impacting on the NICU's ability to function at its full 38-cot capacity. A shortage of nurses had resulted in the department only being commissioned to provide 24 cots, with a total of 27 cot spaces currently available. The division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided.

Parents were mostly complimentary about the care and treatment provided, although they felt there could be improvements and more consistency with communication among the consultant group. Parents felt that staff across all disciplines were compassionate, understanding and caring. Where parents or carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future.

The senior management team were cohesive and it was apparent that all those working in this division were passionate about influencing the care and treatment of neonates. However, there had been a lack of progress in addressing the risks identified in the division. Some risks had been with the management team for over five years; there was little or no evidence to demonstrate that these risks were being addressed in an effective way.

# Neonatal services

## Are neonatal services safe?

Requires improvement



There was openness and transparency when things went wrong, and information was cascaded down to frontline staff after multidisciplinary meetings. However, there was a lack of clarity and robust processes for ensuring that the investigation and learning from incidents which had no or minor harm was disseminated among staff groups, especially when there had been multiple incidents of a similar nature.

While the departments' infection rates were among some of the lowest in the country, adherence to the trust's methicillin-resistant staphylococcus aureus (MRSA) screening policy was noted to be poor. There were processes and guidelines in place to ensure that new-born, pre-term babies were managed in a consistent way during their first hour of life. Staff had access to advanced life support algorithms. The department was secure and there were processes to ensure the safety and welfare of babies.

### Incidents

- Learning from never events was disseminated to staff through the service's quality and safety newsletter, 'The Indicator'. A summary of a recent never event which had occurred within children's services at St Mary's Hospital was included in the July 2014 edition, as well as details about the action taken in response. Two members of staff that we spoke with were aware of the incident and were able to describe the actions that had been taken.
- A total of 226 incidents attributed to the NICU at Queen Charlotte's were reported through the trust's electronic incident reporting system between April 2013 and 22 July 2014. Of these, two were rated as having an 'extreme impact', four 'moderate impact', 32 'minor impact', four 'low harm' and the majority (179) resulting in 'no harm'. Four incidents were also reported to be 'near misses'.
- There was a system for ensuring that incidents reported as having a moderate, major or extreme impact on patients, were appropriately escalated and investigated and that action plans were devised and disseminated accordingly.
- While there was evidence of learning from significant events, it was not clear from our discussions with junior

staff if learning from more minor incidents took place. We noted that, on reviewing the incidents for the NICU on two separate occasions about one month apart, two babies were partially fed breast milk from the wrong mother. Both incidents were logged as 'near misses'. While there was evidence of action being taken to ensure that the babies had not come to any harm, there was no evidence that the milk-checking protocol had been reviewed to ensure that it was suitably robust or whether there was a need for additional training and support for staff.

- Cross-site neonatal meetings took place. Attendees were recorded in the meeting minutes so it was easy for the service to identify who had been present and who was absent, therefore making it easier to disseminate information to those not present.
- The neonatal morbidity and mortality meetings listed action and learning points. The minutes from these meetings demonstrated that outstanding actions were followed up, although it was noted that timescales were not set against each action.

### Harm Free Care

- The NICU routinely participated in the trust-wide, harm-free care initiative, a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data provided by the trust indicated that the NICU attained 100% compliance with harm-free care during 2013/14. Compliance reported for April and May 2014 was also 100%.

### Cleanliness, infection control and hygiene

- During March and April 2014, the NICU reported one serious incident which specifically related to an outbreak of late-onset group B Streptococcus infection which affected four babies. A full root cause analysis investigation had been undertaken, but the cause of the cross-contamination could not be definitively determined. A range of possible causes were considered and there was evidence that action had been taken to resolve those issues.
- A total of seven recommendations were made and lessons learnt were shared with staff working on the NICU. The department welcomed an external review from Public Health England (PHE) which took place on 7 May 2014. Observations from the visiting PHE specialist included, "there was an overall impression of a unit where infection prevention had clearly been given a

# Neonatal services

great deal of thought and was being put into effect with a high standard. Whilst I am able to make suggestions for improvement, these will be added on to a very solid behavioural and procedural base”.

- The unit’s portable ultrasound scanner had been identified as being a piece of equipment which would have been difficult to effectively decontaminate due to its inherent design. The machines were visibly clean on the day of the inspection. Individual sachets of ultrasound gel were available and there was no evidence that multi-use ultrasound gel containers were being used; these had been seen to be in use during the PHE visit and a recommendation was made that these be removed from the department.
- A small number of Medigenic® computer keyboards and mice were located in high-risk clinical areas such as the nurseries; these keyboards allow the surfaces to be fully decontaminated with appropriate anti-bacterial wipes at timed intervals, with visual alerts reminding staff of the need to clean the surfaces. However, a small number of standard keyboards and mice remained in high-risk areas; these keyboards and mouse were less amenable to decontamination.
- Further recommendations made following the PHE visit included reviewing the process for the local decontamination of expressed breast milk collection kits. The lead consultant reported that this recommendation remained under review and that the NICU was working closely with the joint working group, consisting of representatives from the Healthcare Infection Society and Infection Prevention Society to review working practices.
- Compliance with the trust’s MRSA screening policy was reported as 55.7% for 2013/14.
- No cases of MRSA were reported by the NNU April and June 2014.
- One case of methicillin-sensitive staphylococcus aureus (MSSA) was reported between April and June 2014.
- There were low levels of compliance with MRSA screening. Ranging between 0% in June 2014 and 31% in July 2014. The trust reported that this had increased to 71% in August 2014. The NNU matron reported that the low compliance rate was attributed to the collection of data. The trust’s MRSA screening policy stated that all neonates who were admitted to the NNU within the first 24 hours of life should be screened at 48 hours of life and that all other babies should be screened within the first 24 hours following admission to NNU. The matron

told us that, in their opinion, there was compliance with screening neonates in line with the trust’s protocol; if samples were not received into the laboratory and logged within set timescales, this would be considered as a failure to apply the trust’s policy. There was no evidence provided to support this view.

- Three cases of early onset bloodstream infections were reported between April and June 2014 for the NICU.
- Six cases of late onset bloodstream infections were reported between April and June 2014 for the neonatal unit (NNU).
- Compliance with the completion of all components of the trust’s care bundle (or care processes) for peripheral cannula (tube inserted into a patient’s vein) was 86.9% for 2013/14. Performance for April and May 2014 was 80% and 33% respectively.
- The department had a range of equipment which was seen to be clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned.
- We observed staff complying with the trust’s policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- During our observations of the immediate environment where neonates received treatment and care, we found all areas to be suitably clean.
- Where cleaning took place, domestic staff used colour-coded equipment for different parts of the ward.
- We observed staff to routinely wash their hands both before and after patient contacts within the NICU. Parents, visitors and staff were also asked to wash their hands on entering the main unit and again once they entered one of the nursery bays.

## Environment and equipment

- The unit was locked, preventing unauthorised access. Parents/carers and visitors were able to gain access by using a buzzer which was monitored by nursing staff. We saw that a member of nursing or administrative staff greeted each visitor as they entered the unit.
- Parents/carers and visitors had access to a communal area, providing families with an area to take a break away from the cot side.
- Resuscitation equipment was checked daily and staff signed to show that all equipment was available and functioning.

# Neonatal services

- Facilities were available to enable staff to nurse infants in individual cubicles if there were concerns about infectious diseases. The lay-out of the department allowed for individual areas to be closed so that remedial works could be carried out without this impacting on the welfare of sick neonates.
- Equipment was found to be in date. Staff told us there was sufficient equipment available at all times. There were systems to obtain equipment from other units when necessary.
- Staff were aware of who to contact or alert if they identified broken equipment or environmental issues that needed attention.

## Medicines

- There were processes for ensuring medications were kept securely. Medication fridges were noted to be locked when we checked them. Fridge temperatures were routinely recorded to ensure that medicines were stored as per the manufacturers' recommendations.
- Controlled drugs were stored according to legal requirements. Staff were seen carrying out routine stock checks of controlled drugs.
- We reviewed two drug charts; medicines were found to be prescribed by registered medical practitioners.
- There was a process for monitoring the risks associated with the storage, prescribing, preparing and administration of medications. Incidents were reported via the trust's incident reporting system. The departmental risk newsletter, The Indicator detailed the number of incidents reported within paediatrics and neonatology. Where trends had been identified, actions had been taken to resolve issues.
- Staff had access to national formularies such as a local neonatal formulary and the British National Formulary for Children.
- Staff working on the NICU had access to a Total Parenteral Nutrition (TPN) calculator to help ensure that infants were prescribed the correct TPN which met their individual requirements.
- Clinical areas were supported by daily and weekly visits from a paediatric or neonatology pharmacist.
- Through their 'business as usual' processes, the children's pharmacy team reported 271 interventions in pharmaceutical care during a five day audit period in 2013: 33 prescriptions were stopped; 58 prescriptions changed; 33 new prescriptions started; 69 prescriptions

clarified; 13 prescriptions monitored; and 65 information requests. These 271 interventions were considered as a positive intervention and helped to enhance patient safety.

## Records

- The three patients' records we looked at were comprehensive and patient-centred. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.
- During our inspection we noted that records were kept securely.

## Consent

- Staff obtained consent from parents/carers appropriately and correctly. Staff were aware of the importance of identifying those individuals with parental responsibility. There was a policy which supported staff when consent was required for a baby who was a ward of court or looked-after child/neonate.
- We noted that verbal or written consent was obtained for both medical and surgical interventions, with signatures that stated it had been received for written consent.
- One of the parents we spoke with told us that the staff had fully explained the proposed procedure and possible complications before they gave consent.

## Safeguarding

- Staff had an understanding of their roles and responsibilities when reporting safeguarding concerns.
- A policy relating to safeguarding children and young people was readily available and accessible and had been reviewed in July 2014.
- The hospital had a consultant lead, named nurse and named executive for safeguarding children.
- The areas within children's services were supported by a safeguarding nurse who we saw visit each clinical area on a regular basis.
- We were not provided with specific training data for the NNU workforce, with the exception of safeguarding training data for the junior and middle grade doctors. Of this group, 81% had completed level 3 safeguarding children training.
- Staff were made aware of any baby on a child protection plan admitted to the unit by a referring trust.

# Neonatal services

## Mandatory training

- The trust was asked to provide their mandatory training records for each of the clinical areas we visited; whilst we received generic data relating to statutory and mandatory training for each clinical area prior to the inspection, we also asked the trust to provide us with a copy of the training database which was maintained by the NNU matron. The local training database was not provided although we were able to review it during the inspection. Generic data provided by the trust demonstrated that overall compliance for NNU staff completing their mandatory training was 78% as at 31 March 2014.
- The unit had a structured induction programme that all staff completed when they commenced employment.
- Staff were able to access a range of mandatory training which was provided in a variety of ways, including e-learning and face-to-face facilitation sessions.

## Assessing and responding to patient risk

- The NNU did not use any form of neonatal early warning system. However, the department had implemented a 'Golden Hour' policy and guidelines to help improve the outcomes for babies born at less than 32-weeks' gestation; this was achieved with the appropriate preparation of equipment and staff prior to the delivery of the expected pre-term baby and subsequent management of the baby in line with standardised practices as detailed in the guidelines.
- Staff had access to life support and resuscitation processes, including the procedures for neonatal life support.

## Nursing staffing

- Information provided by the trust indicated that, as of September 2014, the establishment for the NICU was 64.9 whole time equivalent (WTE) posts, with an overall vacancy rate of 3.9 WTE (6%).
- It was reported that the NICU's nursing establishment made it impossible for the unit to meet the British Association of Perinatal Medicine standard for babies requiring one-to-one intensive care. This was listed as a risk on the divisional risk register, first entered on 1 December 2011. However, the unit was able to demonstrate that it was meeting the standards for babies requiring special care (1:4 ratio) and high dependency care (1:2 ratio). The department reviewed staffing and patient acuity levels each day, and where necessary additional resources were drawn from

alternative sources including transferring staff from the Winnicott Baby Unit or by the nurse-in-charge accepting a clinical workload, if the acuity of a patient was such that additional nursing support was required.

- Following the publication of the 2013 Royal College of Nursing guidance on staffing, the senior management team undertook a review of the nursing establishment across the service. The nursing establishment was recorded on the local risk register due to a shortage of qualified neonatal nurses.
- Data within the Royal College of Nursing's review of core standards for children's services, August 2014, reported that 70% of the nursing workforce had completed a nationally recognised specialist course in neonatal intensive and special care nurse.
- We were told that a large-scale recruitment drive had taken place in quarter one of 2014 which resulted in the appointment of 30 WTE nurses who were due to commence a one-year rotation programme on 29 September 2014. Five nurses were each being allocated to the NICU at Queen Charlotte's & Chelsea Hospital. We saw that a provisional band 5 rotation and development programme had been introduced by the practice educators so that all new staff were appropriately supported throughout their rotation.

## Medical staffing

- Neonatal intensive care services was supported by a team of 11 neonatal consultants and one academic neonatal reader, who each rotated between the NICU at Queen Charlotte's and the Winnicott Baby Unit at St Mary's Hospital. In total, the consultant team provided 150 programmed activity sessions.
- Consultant neonatologists provided 12 hours of on-site medical cover each day and then further support by an on-call rota.
- The unit was supported by a range of junior doctors with two specialist registrars available on site at night.
- Consultants carried out twice-weekly ward rounds during which time they were available to speak with parents/carers about the care and treatment of their baby. In addition, we noted that there was consultant presence on the unit during the inspection; consultants were present to support staff and to intervene where required.
- Four consultant posts were currently supported by locum consultants.



# Neonatal services

## Security

- There was a security system for entry to the NICU. We observed staff politely challenging visitors to the ward to determine the reason for their visit.
- There was a protocol for dealing with child abduction if the issue arose.

## Major incident awareness and training

- While senior members of the children's team had received training and had engaged in major incident planning, it was not clear from our discussions with more junior staff that any training had taken place to allow them to rehearse the appropriate protocols.

## Are neonatal services effective?

Good



Care was provided in accordance with evidence-based national guidelines from organisations such as NICE and the Royal College of Paediatrics and Child Health. Staff followed specific care pathways and used pain assessment tools to ensure that babies received appropriate care and treatment and effective pain relief. The service ensured that babies' nutritional and hydration needs were closely monitored and maintained.

The matron carried out appraisals for nursing staff, identified training and development needs and maintained records of staff training. However, we noted that there was some disparity between training records kept locally by the matron and those kept centrally by the trust.

A 24-hour, consultant-led service was provided. The service was supported by discharge and liaison nurses, allied health professionals and specialist consultants and services such as clinical psychology and neurology.

## Evidence-based care and treatment

- The NNU used a range of guidelines which had been produced by NICE to define the treatment they provided.
- There were pathways and protocols of management and care for various medical and surgical conditions. We saw documented evidence that these were used and updated appropriately if there were any changes in the national guidelines.
- The unit was seen to use NICE Clinical Guideline 149: Antibiotics for early-onset neonatal infection.

- The unit was accredited by Bliss, the charity for premature babies, as Bliss Baby Charter level 1, the highest level in their audit of best practice levels of care for neonatal units looking after premature babies..
- There were processes for ensuring that clinical services complied with national standards. Examples included the review of the neonatal jaundice guideline against the standards set within the NICE Clinical Guideline 98: Neonatal Jaundice. Action plans were generated where areas of improvement were required.

## Pain relief

- There was a process for ensuring that neonates received oral sucrose as a means of reducing their pain response during procedures such as heel prick blood screening and lumbar punctures.
- We saw that the unit used kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates. Parents reported that they were encouraged to engage in skin-to-skin care on a frequent basis, dependent on the baby's condition.
- Staff that we spoke with demonstrated an understanding of both pharmaceutical and non-pharmaceutical pain management strategies for neonates. However, the unit was not using a neonatal pain assessment tool.

## Nutrition and hydration

- The NNU operated one of only 15 donor breast-milk banks in the country. The milk bank was a member of the United Kingdom Association for Milk Banking. There was a process for the receiving and screening of donor breast milk. This process was supported by the NICE protocol for donor breast milk which we were shown during the inspection.
- During quarter one of 2014, 89% of babies born at less than 33 weeks gestation were solely receiving maternal breast milk on discharge, and 89% of babies were receiving "some" maternal breast milk on discharge.
- There were referral pathways for any neonate identified as being at risk of malnutrition, or for babies who had specialist requirements such as long-term enteral feeding support.

# Neonatal services

- Inpatient dietetic services received a total of 837 referrals, resulting in 3,706 clinical contacts during 2013/14. An additional 687 outpatient referrals were made during the same period, resulting in 2,741 clinical contacts.
- The service employed 6.3 WTE specialist paediatric dietitians. Nutritional services were provided across the range of paediatric services, including neonatology, paediatric intensive care, allergy services, diabetes, haematology, oncology, bone marrow transplant and infectious diseases. The dietetic team reported that an increase in referrals was placing additional pressure on the team to deliver their service in a timely manner.

## Patient outcomes

- There was no evidence that the trust was currently an outlier regarding perinatal morbidity. However, a review of the department's mortality and morbidity performance had been undertaken in 2013 in response to information published by the Dr Foster research programme that neonatal services at Queen Charlotte's had a higher-than-expected mortality rate during 2011/12. It was the conclusion of the review that, "The Standardised Mortality for babies born at QCCH as reported by Dr Foster for 2011/12 suggested that mortality was higher than expected; review of the data revealed it to be flawed because of coding problems".
- The issue with data quality has now been resolved with a lead consultant having been identified to oversee data collection and validation. Attending consultants now also review all discharges and final diagnoses to ensure they are appropriately coded.
- The NNU is one of 29 UK-based neonatal units to submit their performance data to the Vermont Oxford Network, an international benchmarking tool which captures data from approximately 950 neonatal intensive care units around the world. Data submitted to the network during 2012 and 2013 suggests that the mortality rate for this group of babies is now within the expected range, having previously been reported as higher than expected. Concluding commentary from the 2013 mortality review included, "The available data suggests that neonatal mortality at QCCH might have been raised in 2009 and 2010 but that more recently it has been within the expected range; this observation has to be guarded because of lack of comparative data with similar London hospitals".

- Following this review, the department had submitted data to the Neonatal Data Analysis Unit so they could compare their performance against local and national units.
- While the most recent data is grouped by neonatal networks and not by individual neonatal units, the adjusted mortality ratio for the North West London Neonatal Network, which Queen Charlotte's is a member of, is comparable to other networks in England at 1.03 for 2010–2012 (National median rate is 1.0).
- The unit also provided data to the National Neonatal Audit Programme (NNAP).

## Vermont Oxford Network performance:

- The mean hospital-acquired infection rate for 2013 was 9.9% which was significantly better than the UK mean of 19.2% (lower quartile: 7.9% and upper quartile 22.9%).
- Of the 17 key neonatal outcomes which are measured via the Vermont Oxford Network on an annual basis, the NNU demonstrated comparable performance against international centres for all outcome measures.

## NNAP performance:

- Data from the 2011 NNAP listed the Queen Charlotte's & Chelsea Hospital NNU as a positive outlier in three of the four questions selected for additional analysis.

## NNAP performance data across five areas for 2011 and 2012:

- The department provided us with provisional information to indicate that performance had improved in 2013 in those areas that had worsened in 2012 compared to 2011. At the time of writing this report, the NNAP report for 2013 had not been published so it was not possible to verify this data.

## Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)

- The trust regularly submitted data to MBRRACE-UK (a research collaboration based at the University of Oxford which investigates infant and maternal deaths); however, no national performance reports have yet been released.

# Neonatal services

## Competent staff

- The departmental scorecard reported that, as of May 2014, 92.6% of nursing staff had participated in an appraisal. The staff we spoke with told us that they considered the appraisal system to be beneficial to their personal and professional development.
- Staff working in the NNU had access to educational practitioners. Staff we spoke with told us this was received positively and helped them to develop their competency.
- The neonatal team had access to a simulation and practical training suite which enabled the team to rehearse scenarios including neonatal life support and umbilical veno-arterial catheterisation as examples.
- 78% of junior doctors had completed neonatal life support training.

## Multidisciplinary working

- A range of weekly, multidisciplinary meetings took place, allowing staff from across the service to discuss, plan and reflect on patients whose care did not form a standard treatment pathway or where specialist advice was required.
- The department had access to a specialist consultant who re-developed the Imperial College Healthcare NHS Trust perinatal neurology service. The NNU also had immediate access to a specialist neonatal magnetic resonance imaging (MRI) service which was located directly adjacent to the unit.
- The trust provided a dedicated pharmacy team during normal working hours (9.10am – 5.30pm) Monday to Friday. The pharmacy team were noted to be involved in many of the multidisciplinary team meetings that occurred.
- The unit was supported by specialist physiotherapy, speech and language and dietetic services that each provided continued support and advice to families upon discharge of their baby from the unit.
- Medical notes we reviewed included documentation from members of the multidisciplinary team involved in their care.
- Surgical support was provided by a neighbouring neonatal NICU located at Chelsea and Westminster Hospital. Diagnostic images could be shared with the surgical team prior to a neonate being transferred for a formal surgical opinion.

- The NNU was supported by a clinical psychology service who engaged in multidisciplinary clinics such as the neonatal feeding clinic. Staff could also refer parents/carers and families to the team for formal psychology engagement and bereavement support.
- We received feedback from families regarding the clinical psychology service stating that the support they received was “invaluable”.

## Seven-day services

- Staff were able to access radiology services 24 hours per day with urgent electronic reporting available overnight.

## Are neonatal services caring?

Good



Babies and their families were treated with respect and dignity. In general, the parents/carers we spoke with told us that they were involved in deciding treatment plans for their baby. However, there was a concern that the weekly changeover of consultants meant changes to treatment plans which led to inconsistency. This had been acknowledged by the department and consideration had been given to the introduction of named consultants for those babies who were likely to remain on the unit for prolonged periods of time; it was felt that this would provide families, parents and carers with a level of consistent care and familiarity with the clinical team.

## Compassionate care

- Throughout our inspection, we saw staff treat babies and their parents with dignity and respect.
- We saw that doctors and nurses introduced themselves appropriately.
- All of the parents and relatives we spoke with were positive about the caring, friendly staff. They said the care that they and their baby had received was kind, compassionate and supportive.
- Comments from parents/carers included: “The team have been great. They are friendly and helpful”, “we have had a very good service from all of the staff. We have had good communication throughout the process, both antenatally and following the birth of our baby,” and, “we appreciate so much all the fantastic care we received and the incredible support you gave us in the journey of healing”.

# Neonatal services

- As of April 2014, neonatal services at Queen Charlotte's engaged in the NHS Friends and Family Test. The unit attained a composite score of 76 in April 2014, 71 in May 2014 and 100 in June 2014.

## Patient understanding and involvement

- The unit provided outreach nursing support to parents/carers whose baby was scheduled to be discharged home after having received treatment in the unit.
- We observed consultant ward rounds taking place on the NNU. Parents were present for the handover; the consultant spent time speaking with the parents and provided many opportunities for them to ask questions about the care and treatment plans for their babies.
- However, one parent reported that, due to the regular changeover of consultants, treatment plans would sometimes change, and that there was not always a consistent approach to how their baby was treated. This comment was further reflected in information we received prior to the inspection and also from reviewing parent/carer feedback. This had been acknowledged by the clinical lead who was exploring a range of options, including long-term babies being assigned named consultants so that continuity of care could be guaranteed in the future.

## Emotional support

- We saw families being reassured by the nursing staff and heard explanations of their care being given.
- Parents spoke positively about their engagement with the discharge and liaison service.
- The discharge and liaison service offered parents/carers bereavement support. This service was backed up by the clinical psychology team who were available to provide follow-up support after bereavement. Parents/carers who endured the loss of their baby were invited back to the unit to meet with a consultant and clinical psychologist about six weeks after their baby had died to help them to understand the cause of death and to facilitate the grieving process.
- There were processes for supporting the parents/carers and siblings of babies receiving palliative care. This included the development of age-appropriate books for siblings aimed at helping them to understand the concept of death.

## Are neonatal services responsive?

Good



It was acknowledged by the trust that the NICU was not able to operate at full capacity due to a national shortage of specialist neonatal nurses. It is acknowledged nationally that there is a need for additional specialist neonatal cots to be made available; the clinical team confirmed this and were trying to recruit sufficient nursing staff to meet local and national demand.

The department was able to offer local accommodation to parents and families. The environment had been designed to meet the needs of the population. There was evidence that the department learnt from complaints.

## Service planning and delivery to meet the needs of local people

- The service had systems for monitoring the service they delivered as well as anticipating the needs of the service for the future.
- Paediatric site practitioners and neonatal coordinators had been employed to oversee the day-to-day operational running of the service, having input into the admissions and discharges of each clinical area.
- Twice-daily unit meetings took place, allowing the nurse-in-charge from each clinical area across the children's and neonatal service to discuss their bed occupancy, upcoming discharges, elective and emergency admissions.
- We observed the nurse-in-charge from the Winnicott Baby Unit at St Mary's Hospital liaise with the medical and nursing team at the NICU at Queen Charlotte's via a video link. This enabled the team to function as one service, discussing discharges and admissions across the service, as well offering the team an opportunity to discuss operational issues such as staffing issues.

## Access and flow

- Between April 2013 and March 2014 the NICU admitted a total of 444 neonates. This was slightly higher than the previous year's 415 babies.
- The number of care days for 2013/14 totalled 2,917 for babies requiring intensive care, 1,580 days for babies requiring high dependency and 2,581 for babies requiring special care.
- Combined with the unit's sister department – the Winnicott Baby Unit at St Mary's Hospital, the neonatal

# Neonatal services

intensive care services at Imperial College Healthcare NHS Trust refused 65 babies during 2013/14. Of those, 59 were in-utero refusals (12 were from the local North West London Neonatal Network and 47 from outside the network), and six ex-utero refusals (three from the network and three from outside).

- It was acknowledged by the neonatal team that the service had scope to expand their neonatal services to meet the demand for specialist neonatal intensive, high dependency and special care cots.
- The neonatal team reported that the main barrier to expanding the number of cots was the appointment and retention of specialist neonatal nurses; specialist nurses with experience of working in neonatal intensive care units was listed on the April 2014 UK government's occupation shortage list, meaning that international visa applications would be considered for those nurses with the appropriate skills.

## Meeting people's individual needs

- The NNU operated flexible visiting times to allow for families to support the parents/carer's whose baby or babies were on the unit.
- Translation services were available for patients and families for who did not speak English as their first language.
- Information boards were sited around the hospital and in the relative's room, providing a range of information.
- Screens were used appropriately where parents/carers had requested a period of privacy or where mothers wished to express breast-milk while at their baby's cot.
- The NNU had nine parent/carer accommodation rooms which were located directly adjacent to the unit. This allowed parents/carers to be close to their baby and was especially helpful for those parents/carers who had been transferred from hospitals located outside London.
- Medical staff from a range of clinical settings raised concerns that there was limited access to neurophysiology services within paediatrics and neonatology. The directorate risk register listed this as an area of risk and had been first reported on 1 January 2006. An update to the risk register in June 2014 indicated that the provision of this support would worsen following a reduction in the neurophysiology

workforce, further impacting on the timely reporting of neonates and children referred for neurophysiology opinions. There was no clear plan detailing how the risk was to be managed and resolved.

- The department had received funding to refurbish a parent accommodation room and convert it into a dedicated bereavement suite. The Winnicott Room was acknowledged by families who had suffered a loss of their baby as being a valuable resource, allowing them an opportunity to spend time with their baby during their last hours of life.

## Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). A dedicated member of staff within the unit reviewed all formal complaints received and concerns raised with PALS.
- Information was readily available for parents/carers who wished to make a complaint, but who may have needed support to do so.
- Overall, the percentage of complaints lodged against the department, considering the number of admissions and attendances, was low (0.4%).
- There was evidence that complaints were shared with members of the team so that lessons could be learnt. This included the lead consultant reviewing the management of neonates who required long-term care to determine whether they could be assigned named consultants as a means of ensuring consistency with treatment pathways as well as providing a level of familiarity with the family/carers.
- Trends arising from complaints were discussed as part of the clinical governance system within the department, from which a quarterly complaints report was produced detailing the nature of complaints and any specific trends.

## Are neonatal services well-led?

Requires improvement



There was a risk register for the directorate and risk management issues were discussed at directorate meetings. However, although risks had been identified, there was not always an action plan to resolve issues, with

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some risks being present on the register for five or more years. Furthermore, additional work was required to ensure that local risk management systems were suitably robust and embedded into practice.

There was a strong, positive and caring ethos within the unit. However, some staff reported that some clinicians were likely to adopt individualised practice instead of applying the unit's clinical protocols; this, some staff reported, led to an inconsistent approach to clinical treatments of the sick new-born.

While our inspection focused on acute services, we noted that there was a range of clinical research and academic study being undertaken by neonatal healthcare professionals.

## Vision and strategy for this service

- The department had considered a range of developments to further enhance the provision of services for in the future.
- There was an active emphasis on the implementation and sustained compliance with the standards set out in the Department of Health's National Service Framework: Children, Young People and Maternity Services, which was now in its final year of a 10-year programme.
- Staff across the various clinical areas were able to describe the vision for children's services at Imperial College Healthcare NHS Trust.
- There was a focus on clinical research within neonatology and neonatal intensive care.
- The vision of the service was in line with the trust's wider clinical strategy and service transformation plans. For example, it was noted that neonatology services would continue to be provided on two sites, albeit with a transfer of the NICU to the St Mary's campus and the NNU moving to Queen Charlotte's. Some clinicians had hoped that the service would be solely provided on one campus in the future, but this was not to be the case when reviewing the clinical strategy.

## Governance, risk management and quality measurement

- Governance meetings took place and there was discussion regarding incidents and complaints. However, we were told that additional work was required to strengthen the governance system within the NICU. While risks were reviewed at divisional level, there was no robust system in place for routinely reviewing incidents at a more local level. We were told

that, prior to April 2014, routine monthly meetings took place to look at the Datix data on patient safety incidents. The meetings were attended by the clinical and nursing leads, divisional risk nurse and allied healthcare professionals such as pharmacists. These meetings had stopped following the clinical restructure of the divisions. We found that there were 40 incidents logged on the Datix system against the NICU, of which 24 were listed as "pending" and "overdue". It was acknowledged that a new risk management process was being introduced but was described as, "a work in progress which was slowly evolving". This included two weekly meetings which were to be attended by the lead consultant, lead nurse and the risk and audit nurse. Consideration was also being given to submitting a business case to create a quality and risk nurse role dedicated to the neonatal service, however, this remained in the very early stages of planning.

- Risks associated with the provision of services were logged on the divisional risk register. While there was evidence that risks were discussed and updates applied to the register, we noted that some risks (seven in total) had existed for five or more years with little or no progress being made to resolve the issues.
- A perinatal scorecard and a harm-free dashboard was used to help monitor the overall quality of services being provided to neonates.

## Leadership of service

- Leadership on the NNU was strong and embedded. A new matron had been appointed to the Winnicott Baby Unit, meaning that there was less pressure on the existing matron at Queen Charlotte's to provide support and leadership across two sites.
- However, while there had been an effort to amalgamate the Winnicott Baby Unit and the NICU located at Queen Charlotte's Hospital into one complete service, there remained a degree of separation among the nursing staff; there was no formal rotation of nursing staff and so it was difficult to consider that both units were operating as one seamless service.
- The medical team rotated across the two units so as to ensure consistency with medical treatments as well as integrating the two units from a medical perspective.
- The matron reported that having supernumerary status allowed them the time to carry out the full leadership role.

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- Staff told us that they felt well-supported by their matron.
- A small number of staff raised some concerns that there was a degree of individualised clinical practice, with some practitioners not always following local protocols and policies, making it difficult for the unit to provide consistent care and treatment to neonates.
- At the time of the inspection, neonatal, children and young people's services did not have a named non-executive board member representing them at board level.

## Culture within the service

- The staff we spoke with were proud to work at the trust and felt it was a centre of excellence.
- There was a culture of openness and staff felt able to report concerns.
- The service had an open and friendly approach, with team working among the clinical specialities reported as strong and effective.

## Public and staff engagement

- The trust used a range of systems to seek feedback from parents and carers. This included an electronic patient tracker system which was located on the wards. Information from the tracker system was relayed to staff on a monthly basis via the staff communication board.
- Parent/carer feedback was widely displayed throughout the department.
- There was a range of systems in place to seek the engagement of members of the public, including parent groups. A weekly parent group was facilitated by a clinical psychologist who was able to provide guidance and support to those families whose baby was receiving treatment on the unit.

## Innovation, improvement and sustainability

- Engagement in neonatal research was a key objective of the unit. The unit had, and continues to lead and participate in research, including the TOBY children study on whole body hypothermia for the treatment of perinatal asphyxial encephalopathy, the TOBY Xenon

study on the neuro-protective effects of hypothermia, and the ePrime study on the evaluation of MRI to predict neurodevelopmental impairment in preterm infants. The unit had also engaged in the European Pain Audit in Neonates (EUROPAIN Survey) which considered the current clinical practices regarding the use of sedative and analgesic drugs in neonates.

- The unit had introduced the use of headphones on the unit so that parents were encouraged to be present for ward rounds. Historically, to help maintain patient confidentiality during ward rounds, parents/carers were asked to leave the NNU when other patients were discussed; the use of headphones, attached to music, meant that parents could not overhear conversations about other babies. Since the introduction of the headphones in April 2014, the number of times a parent/carer had been asked to leave the unit during ward rounds or handovers had decreased by 70%.
- Two lactation consultants from the department continued to provide support and guidance to neonatal nurses and midwives in developing countries, including Rwanda. The two staff members were currently developing a three-day lactation and breastfeeding course to help support neonatal nurses in Rwanda; they were developing links with the Democratic Republic of the Congo to enhance and develop the provision of care for sick new-borns.
- The unit reported that, in 2013, a group of neonatal mothers had been invited to attend a filmed focus group to discuss the support they received while on the unit. Clips were shown to a national audience during Imperial College's neonatal feeding conference; themes from the feedback included the importance staff had placed on ensuring that the mother's own needs were addressed as much as those of the baby, as well as the importance of ensuring that both the maternity and neonatal service liaised with each other. Educational opportunities and practical advice and support were also identified as being important to mothers and other family members while their baby received treatment.

# Outstanding practice and areas for improvement

## Outstanding practice

The hospital has a focus on participating and leading national research projects, including the evaluation of magnetic resonance imaging to predict neurodevelopmental impairment in preterm infants.

## Areas for improvement

### Action the hospital MUST take to improve

#### The hospital must:

- Review the staffing levels and take action to ensure they are in line with national guidance.
- Review the capacity of the maternity and neonatal units to ensure the services meet demands.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.

### Action the hospital SHOULD take to improve

#### The hospital should:

- Review the current arrangements to ensure that the oversight of compliance with mandatory and statutory training is suitably robust and to ensure that records held in clinical areas is consistent with those held centrally at trust level.
- Ensure that the risk management process within the neonatal division is suitably robust and fit for purpose to ensure risks are assessed, investigated and resolved in a timely manner.
- Explore how staff can learn from minor incidents and near misses to avoid similar incidents occurring.
- Consider the neonatal service having representation at board level.



This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing  People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there were not sufficient numbers of nursing staff on the neonatal intensive care unit and maternity wards.  Regulation 22