North West London Hospitals NHS Trust  
Northwick Park Hospital

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<th>Region:</th>
<th>London</th>
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<td>Location address:</td>
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<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<td>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse</td>
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<td>Diagnostic and/or screening service</td>
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<td>Date of Publication:</td>
<td>October 2011</td>
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<td>Overview of the service:</td>
<td>Northwick Park Hospital is a major acute</td>
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hospital in north west London, managed by North West London Hospitals NHS Trust. Acute hospital services are provided to more than half a million people living mainly in the London Boroughs of Brent and Harrow. This was a review of maternity services at the hospital. The maternity unit includes a midwife-led birth unit as well as a consultant led unit. More than 5,000 babies are delivered at in the maternity unit each year.
Our current overall judgement

Northwick Park Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 5 September 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We visited the antenatal ward, postnatal ward and delivery suite in the maternity unit and spoke to a number of women and their partners. All of the women told us of positive experiences in the unit. They described the midwives as competent and caring and said they always had time for them. A range of information was provided to women and their partners both antenatally and postnatally thus enabling women to take decisions about their care and the birth of their baby. Women felt safe and said staff were approachable. One-to-one care from a midwife was provided once a woman was in established labour and all women were offered skin to skin contact with their baby immediately after delivery.

What we found about the standards we reviewed and how well Northwick Park Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who used the service were treated with dignity and respect by staff. Sufficient information was provided to enable them to make decisions and choices in relation to care and treatment. Care was patient centred and, as a result, peoples' needs were met. Overall, we found that Northwick Park Hospital was meeting this essential standard.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Care and treatment were explained to women in a way in which they understood and...
suitable arrangements were in place for obtaining valid consent. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights**

People who used the service were positive about the quality of care and treatment they received. Women received care and treatment that met their needs and minimised risks to their safety. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Staff understood how to recognise and respond to concerns in relation to safeguarding vulnerable adults and children. Women and their babies were protected from abuse or the risk of abuse. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

There were sufficient numbers of suitably qualified staff to ensure the safety of women and babies and meet their needs. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Staff were supported to perform their role effectively and had undertaken training in areas relevant to their professional role and development. The needs of women and their babies were met by competent staff. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The quality of service provided was regularly monitored. There was evidence of learning and changes in practice in response to incidents and feedback. Risks to the safety of women were assessed and managed effectively. Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We observed care given to women in the delivery suite, antenatal and postnatal wards. The women appeared well cared for. We saw staff talking to patients and interacting positively and sensitively with them. Women and their partners in the antenatal and postnatal wards found staff approachable.

The privacy and dignity of women was respected. Curtains were kept closed and women confirmed that their privacy needs were respected. We saw staff knock on people’s doors and wait for an answer before entering.

Women and their partners told us they had been kept well informed about their care and treatment. They provided us with numerous examples of being central to their plan of care and support. People told us that tests and scans were explained fully in a way they could understand. Several women told us they had been given information about screening and lifestyle issues antenatally. Partners told us they felt involved and included throughout and we saw partners being welcomed and involved in care. One woman’s comments summed up the experiences of many others: ‘I'm in control of my own birth’. Women were given enough information to make choices in relation to their pregnancy and delivery.
Women told us they were asked about their needs when they were admitted to the ward. One woman told us that her assessment had been ‘good’. Records confirmed that people had their needs assessed throughout their care on both the antenatal and postnatal wards. There were plans in place in relation to the management of the women’s care and treatment.

The women we spoke to told us that they had been offered a choice in regard to where they had their baby. They had received support from a regular midwife during pregnancy and had a birth plan in place. Postnatal women said that they had had skin to skin contact with their baby immediately after delivery.

The bathroom facilities were mostly accessible to people. Although it was more difficult for women in the high dependency area and they had to use toilets in the delivery rooms which were not being used. Senior managers told us that a business case for more toilet and bathroom facilities had been approved and these were due to be provided within six weeks.

**Other evidence**
The maternity unit offered consultant led care and there was a separate area where midwifery led care was provided with six beds. There were two birthing pools available to women to aid pain control and for delivery. Women were offered midwifery-led care at antenatal appointments where births were considered low risk and women met the safety criteria.

Staff we spoke to had showed awareness of people’s religious, cultural and language needs. The senior manager told us about the hospital’s guidance and approach to women who had undergone female genital mutilation. She told us there was a specific staff member who had expertise in this issue. Midwives of Somali origin ran a group offering support to pregnant Somali women.

Interpreting services were accessible 24 hours a day and we were told they were frequently used. We saw information displayed on how to contact an interpreter. Staff also told us that there were midwives and other staff who spoke languages other than English and could help with communicating with women and their partners.

We reviewed a number of maternity records and saw that screening and a range of tests had been offered to women. Case files contained information and booklets given to women regarding antenatal and birth related issues. This helped women to make informed choices.

A range of antenatal classes were provided for mothers and partners. There was a specific class for fathers. Parentcraft classes involved discussions about the types of pain relief available.

**Our judgement**
People who used the service were treated with dignity and respect by staff. Sufficient information was provided to enable them to make decisions and choices in relation to care and treatment. Care was patient centred and, as a result, peoples’ needs were met.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 02: Consent to care and treatment

What the outcome says
This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement
The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
We asked women whether they had been asked to give consent to treatment. They confirmed that care and treatment had been explained to them in detail and in a way they could understand. All the women we spoke to said that staff always asked for their consent before procedures were carried out.

Other evidence
We reviewed a number of health care records and these showed evidence that consent had been obtained from women for the taking of blood and for giving Vitamin K to the baby. Consent forms had been signed by women for surgical procedures.

Staff told us that women were asked to consent to screening procedures during the antenatal period and any risks involved were discussed with them. Women were asked before delivery about the administration of Vitamin K to babies and the use of other medication.

Our judgement
Care and treatment were explained to women in a way in which they understood and suitable arrangements were in place for obtaining valid consent.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 04: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke to a number of women and their partners about their experiences in the maternity unit. Women told us that they had received consistent antenatal care from the same community midwife during pregnancy. They spoke of receiving information on screening and staff had discussed smoking, alcohol consumption and other lifestyle choices with them. Specialist antenatal clinics were provided for diabetic women.

Everyone we spoke to described positive experiences in relation to their care and support. One woman said she was 'very pleased with the service' and her delivery and stay in the unit had been 'a lot better' than she thought it would be. Women felt involved in decisions about their care and said that staff were respectful. Partners told us that they felt they were welcomed and kept informed about the birthing process.

Most women told us that pain relief had been generally sufficient although one woman told us she had to wait a while for an epidural as the anaesthetist was 'busy'.

All women who had already delivered their baby told us they had received one-to-one care from a midwife once they were in established labour and were not left alone. They all told us that the baby was put promptly onto their chest to ensure immediate skin to skin contact after birth.

Women told us they had received advice on to how to care for their baby and in relation to breast feeding. It was evident from talking to people and from information displayed that breast feeding was promoted and women were supported to breast feed. For
example, one woman told us that a midwife had come to see and offered breastfeeding support everyday since the birth of her baby. Women told us they had been fully involved in the development of their birthing plan.

Babies were checked by a doctor or midwife and had hearing tests before being discharged home.

**Other evidence**

We reviewed a number of care records and plans. Care plans included comprehensive assessment information and evidence of plans being reviewed and updated as needed. These included risk assessments. Medical and nursing staff had completed detailed records of care. We saw doctors and midwives accessing records and making notes in care plans during our visit to the unit. Records showed that perineal repair took place very soon after delivery in line with best practice.

There was evidence of screening for haematological conditions and foetal abnormality in women's records. Antenatal notes included questions on smoking and alcohol consumption.

Postnatal records included information given to women on breastfeeding support. There were two dedicated breastfeeding midwives who supported women to breast feed. All midwives had received specific training in breastfeeding. The maternity unit had achieved Baby Friendly accreditation by UNICEF at level 2. Implementing Baby Friendly best practice standards was seen to improve breastfeeding rates amongst women.

**Our judgement**

People who used the service were positive about the quality of care and treatment they received. Women received care and treatment that met their needs and minimised risks to their safety.

Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 07:
Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Women told us that they felt safe and described staff as approachable. They were confident that they would be listened to if they had a concern. A person using the service gave us an example of how staff responded appropriately and promptly when she had asked not to be seen by a particular doctor. People told us they felt listened to.

We observed that staff were vigilant and challenged people who entered the ward who were not staff members wearing identification. We saw one man asked to wait outside the ward whilst his visit was discussed with his partner. This demonstrated that staff took seriously issues of safety and security in relation to women and their babies.

Other evidence
Staff told us that any safeguarding concerns in relation to women and their babies were picked up antenatally. Midwives had access to the ‘at risk’ register and where there were concerns these were highlighted. Where risks were identified an individual plan was put in place. The plan clarified who was involved in the care of the woman, access arrangements and who could visit.

Midwives received training in safeguarding vulnerable adults annually. They were aware of signs of possible abuse or risks to the baby and knew what action to take if they had concerns.

There was a dedicated safeguarding midwife and increased post delivery home visits could be put in place to support women if deemed appropriate. All staff we spoke to
knew who the safeguarding lead was and said she was easy to contact.

Staff asked all women at antenatal appointments about experiences of domestic violence. Women were given information on the support available to them if appropriate.

**Our judgement**

Staff understood how to recognise and respond to concerns in relation to safeguarding vulnerable adults and children. Women and their babies were protected from abuse or the risk of abuse.

Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 13: Staffing

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Women and their partners told us that they felt there were generally enough midwives on duty. Their call bells were answered quickly unless midwives were very busy. They told us that staff had enough time to answer questions and were respectful. One woman's comment was typical, 'staff are wonderfully friendly'. Another person said the midwives, 'always have time to talk to you'.

All the women we spoke to said they had received one-to-one care from a midwife once they were in established labour. One woman told us she had had one-to-one care involving three different midwives over the course of two days in labour.

One person told us that during their antenatal care there was a lack of consistency in relation to the doctor she saw at appointments. She commented, 'it would have been nice to see one doctor'. Another woman said she 'did not need much attention from doctors'.

One woman told us that she had waited in triage before admission to ward because an emergency caesarean was taking place. She said that staff had kept her fully informed about the delay and why she had to wait.

Other evidence
Midwives told us they felt there were generally enough staff on duty, though there were very busy times. They told us that there had been significant recruitment of midwives during the last year which had made a positive difference to their work. One midwife
told us that staffing levels were good and midwives were ‘happy’. She said that this in
turn made women happy. Bank or agency staff were used when there was a shortage
of midwives. The eligibility of agency midwives to practice was checked. Midwives told
us they were able to obtain more staff if the needs of women required it.

The Trust undertook a regular analysis of staffing needs in the maternity unit and
midwife vacancies had been substantially reduced over the last year. There were
reported to be currently three midwife vacancies compared with 40 in January 2010.
The ratio of midwives to births was 1:30, similar to levels in other London maternity
units.

Midwives and managers told us that the number of high risk women coming to the unit
had increased as well as the number of babies delivered at the hospital each year. The
number of births was said to have increased by more than 9% in the last 18 months
and 5,296 babies a year were delivered last year. As a consequence the Trust had
identified the need to increase the number of consultant obstetricians in line with the
Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (see outcome
16 for more detail).

**Our judgement**
There were sufficient numbers of suitably qualified staff to ensure the safety of women
and babies and meet their needs.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 14:
Supporting staff

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
The women we spoke to expressed confidence in the maternity staff supporting them. They considered doctors and midwives competent and able to carry out their roles safely and effectively.

Other evidence
Staff told us they felt well supported and could contact the supervisor of midwives at anytime. There was a ratio of about one supervisor for every 20 midwives. We were told that two new supervisors had been trained and this would improve the ratio and bring it closer to recommended levels. Supervisors met formally with midwives to set annual objectives and identify training needs.

One midwife referred to her supervisor as 'wonderful' and pointed out where the telephone number for the supervisor was on display in the ward. Midwives could contact the supervisor of midwives at any time. The supervisor was also available to help with home deliveries.

Staff described managers as approachable and said that the Matron visited the ward everyday.

Midwives had received training in a range of areas pertinent to their role. For example, they had undertaken update training in cardiotocograph (CTG) monitoring and interpretation. A training needs analysis conducted by the Trust showed that 75-80% of obstetricians had undertaken recent CTG training and courses were being run twice a year.
Guidelines, including NICE (National Institute for Clinical Excellence) guidance, were available for staff and easily accessible to them. These covered topics such as post-partum haemorrhage.

**Our judgement**
Staff were supported to perform their role effectively and had undertaken training in areas relevant to their professional role and development. The needs of women and their babies were met by competent staff.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

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<td>What people who use the service experienced and told us</td>
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<td>All the women and partners we spoke to were positive about the quality of service provided to them. One woman told us she knew the hospital well as she had delivered her first child in there. She said she had 'moved house' to be in the hospital locality because of her previous positive experience.</td>
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<td>We saw numerous 'thank you cards' displayed with some very positive comments from parents about the service provided on the wards. One comment we saw on a thank you card in the delivery suite was typical, 'Thank you for not only helping us deliver our lovely baby but more importantly making that day one of the most beautiful memories of our life'.</td>
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<td>Other evidence</td>
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<td>Staff told us they knew when and how to report incidents and near misses and felt confident in completing incident forms. They received feedback on incidents. Supervisors of midwives were informed of all incidents and these were discussed at the daily 'morning meeting' with all staff on duty. Case discussions took place on a regular basis and learning from incidents and near misses shared widely with staff in the unit. Incident trends were identified and acted upon.</td>
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<td>Midwives told us they felt able to raise concerns with managers or the supervisor of midwives if they needed to. They were confident that they would be listened to by managers.</td>
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New policies and changes in practice were cascaded to staff via the intranet, monthly newsletter and team meetings.

The Trust had carried out benchmarking exercises against National and Pan London reports on maternal deaths, the results of which were communicated to the Trust Board in July 2011. These compared the Trust's maternity performance with the top ten recommendations of the reports. Consequently the Trust identified the need to increase the number of consultant obstetricians in order to ensure 98 hours of consultant presence on the maternity unit in line with RCOG guidelines. The benchmarking exercise also showed that the Trust was already compliant with most of the recommendations arising from the reports.

The Trust carried out an analysis of trends in serious untoward incidents in maternity between 2009 and 2010. Following this an action plan was put in place to address areas where improvements could be made and risks to women reduced. There were plans in place to repeat the analysis annually.

The Trust was about to implement a new system of gathering feedback from people who used the maternity services. A set of 22 questions for women had been developed aimed at measuring women's satisfaction with the service and identifying the need for any improvements.

Patient partnership meetings were held monthly. At these meetings women who had used the service gave feedback on their experience on the maternity unit to staff and students.

Our judgement
The quality of service provided was regularly monitored. There was evidence of learning and changes in practice in response to incidents and feedback. Risks to the safety of women were assessed and managed effectively. Overall, we found that Northwick Park Hospital was meeting this essential standard.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
### Information for the reader

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| Postal address | Care Quality Commission  
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|                | Newcastle upon Tyne  
|                | NE1 4PA |