Care Quality Commission

Croydon Health Services NHS Trust

Croydon University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Croydon University Hospital

Requires Improvement 

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

Croydon Health Services NHS trust provides integrated NHS services to care for people at Croydon University Hospital (CUH) and Purley War Memorial Hospital (PWMH). Services are provided to a population of approximately 383,000 people. Croydon University Hospital is based in South London. The population has a high level of deprivation compared to England average and has the youngest population of any London borough. Data shows that approximately a third of the population are aged under 25. Croydon Health Services is the main provider of maternity care for local women and undertakes approximately 3,500 births per year. The maternity service at the hospital comprises of a consultant led delivery suite, birthing pools, midwifery led unit, home birthing team, a dedicated operating theatre, recovery area, antenatal clinic, antenatal and postnatal wards, day assessment unit and a triage area.

We last carried out a comprehensive inspection of the maternity and gynaecology service in June 2015. The service was rated requires improvement for safe and good for effective, caring, responsive and well-led. The service was judged to be good overall. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

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

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

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions. During our inspection, we visited all clinical areas in the service including labour ward, theatres, antenatal and postnatal wards, the birth centre, antenatal clinics and the day assessment unit. We spoke with 41 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives, matrons, ward co-ordinators, the risk and governance team, the safeguarding team and support staff. We reviewed five medical care records and five prescription charts. We reviewed a range of equipment including resuscitation equipment, grab bags, birthing pools, beds, mattresses, resuscitaires and cardiotocography (CTG) devices. We also reviewed the trust's performance data and observed two multidisciplinary meetings and two handovers.

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

Maternity

Good

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

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. Staff were focused on the needs of women receiving care and were clear about their roles and accountabilities.
- The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to continually improving services.

However:

- The service did not always maintain and service equipment. They did not manage medicines well.
- Policies and guidelines were not always reviewed in line with their review date.
- Not all staff had received their annual appraisal to make sure they were competent for their roles.
- Some final year student midwives experienced delays in completing the required number of deliveries needed to complete their midwifery training programme.

Is the service safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. At the time of inspection, the overall mandatory training completion rate for staff was 92%, which was better than the trust target of 90%. Mandatory training was comprehensive and met the needs of women and staff.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had systems to monitor staff mandatory or maternity specific training, which highlighted when training was needed and gave a good oversight of completion. Practice development midwives (PDMs) and specialist midwives were involved in staff training and staff told us their training was updated regularly in response to any local incidents or risks identified in the service. Temporary staff were required to provide evidence of mandatory training compliance from their employers.

Core skills training was delivered face to face and online. Topics included, but were not limited to information governance, infection prevention and control and manual handling. Mandatory training was comprehensive and met the needs of women and staff. Staff understood their responsibility to complete mandatory training.

The hospital provided doctors and midwives (including community midwives) with maternity specific skills training and signed off competencies in addition to mandatory training. This covered areas such as fetal monitoring, Practical Obstetric Multi Professional Training (PROMPT), newborn basic life support (NBLS) simulation and cardiotocography (CTG) training. Maternity specific training data showed the midwifery and medical staff were mostly compliant with their training. However, staff were not meeting the trust target on the growth assessment protocol (GAP) and gestation-related optimal weight (GROW) training. The completion rate for GAP and GROW training was 78% at the time of inspection, against 90% target.

Staff completed Practical Obstetric Multi Professional Training (PROMPT), training which is a standardised course covering practical training scenarios such as the management of obstetric emergencies. During the inspection, the maternity service had an overall completion rate of 95%, which was better than the trust target of 90%. Midwives achieved 95% compliance, maternity assistant and support workers achieved 92% compliance, senior house officer (SHO) medical staff achieved 93% compliance, and other medical and theatre staff achieved 100% compliance. Staff spoke highly of the delivery of PROMPT training and told inspectors it was one of the best sessions they had attended. They enjoyed the teaching sessions as it provided opportunity for questions and learning from colleagues.

Clinical staff received annual training to interpret and categorise CTG results. Evidence provided by the hospital showed, the overall completion rate for the CTG training was 95% against a trust target of 90% as of 31 December 2022. Staff also told us they attended the weekly CTG meeting which was used as a teaching session to review cases in the service.

During our inspection, we noted that 94% of midwifery staff and 100% of neonatologists had completed the newborn basic life support (NBLS) training.

Staff told us the maternity specific training took a multidisciplinary approach and they had found it useful to improve their practice. Staff also spoke positively about the support received by their managers to complete external specialist courses relevant to their role such as the university-led maternity Masters programme and a diabetic training course.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had clear systems, processes and practices to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The trust had safeguarding policies, guidelines and pathways which guided staff on safe practices. Staff followed the baby abduction policy and undertook baby abduction drills.

Maternity

The completion rate for the level 3 safeguarding children training was 96% against the trust target of 90% as at 31 November 2022. This was an improvement from the last inspection. Staff we spoke to knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples where staff had responded appropriately to safeguarding and security concerns and had involved safeguarding and external agencies such as the police to ensure the safety of women and babies. Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff told us they had attended bespoke unconscious bias training and cultural webinars due to high complex safeguarding cases they saw in their population. Staff told us this had helped them to deal with their own bias and also empowered them to manage safeguarding concerns they came across effectively.

The maternity service had a designated safeguarding team and specialist midwives that provided further support, supervision, training and updates for staff and participated in serious case reviews.

The named midwife for safeguarding had developed a homelessness pathway due to the increase in homeless cases seen in the service. This guided staff to support women and their babies to ensure their safety and timely discharge from the hospital.

The safeguarding midwife and continuity of care team told us they had good working relationships with social services, the homeless team, the family nurse partnership, the police, the Home Office, charities, the perinatal mental health team, local communities and drug and alcohol support services, to support vulnerable women and babies. The safeguarding midwife was part of the Royal College of Midwives (RCM) consultant midwifery network where members were able to share guidelines and best practice. This had helped in improving the safeguarding provision in the service.

We observed comprehensive verbal and written handovers for safeguarding concerns. We noted safeguarding concerns or cases were discussed at handover, safety huddles and various governance meetings. We observed the labour ward handover and noted that safeguarding concerns were also highlighted to staff at the beginning of their shifts to ensure follow-up of care and assessment. We reviewed 5 records and saw evidence of safeguarding referrals and the involvement of social services, GP and health visitors where safeguarding concerns had been identified.

The service had a continuity of care team, family nurse partnership, enhanced care team, specialist midwives and safeguarding team that supported vulnerable women and young adults. We saw examples where multidisciplinary team (MDT) staff such as paediatrics, family nurse partnership (FNP), psychiatrists, social services, learning disability nurses, sexual health staff, midwives and medical staff had worked together to support vulnerable women with safeguarding concerns. Staff gave examples of how the MDT had worked collaboratively and supported each other to deal with 11 complex safeguarding cases. Staff also attended internal and external safeguarding meetings such as named professionals meetings, vulnerable women meetings, case conferences and child in need meetings.

The service ran a specialised fortnightly clinic for women who had undergone female genital mutilation (FGM) with access to the specialist obstetrician, midwives and psychological support to ensure better birth planning. Staff held regular joint safeguarding and perinatal mental health clinics to support vulnerable women. The service had system to track and support vulnerable women and families subject to a child protection or child in need plan.

The service held regular group and one to one safeguarding and restorative supervision for the community maternity staff. The safeguarding supervision was recently rolled out to hospital staff due to the high complex safeguarding cases they had in recent months.

Maternity

Cleanliness, infection control and hygiene

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

We inspected all areas of the maternity unit including the labour ward, obstetric theatres, wards and midwife led birth unit. Ward areas were clean and had suitable furnishings which were clean and well-maintained. The medicines and milk fridges were clean and hygienic. Ward areas were clean and had suitable furnishings which were clean and well-maintained.

There were systems to ensure the deep cleaning of rooms following a discharge or transfer. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Green 'I am clean' stickers were in use in the maternity areas.

Staff followed infection control principles including the use of personal protective equipment (PPE), bare below the elbow and adhered to the trust uniform policy.

Women who were booked for elective caesarean section (c-section) were screened for methicillin-resistant Staphylococcus aureus (MRSA) during their pre-operative assessment appointment. The 5 records we reviewed confirmed MRSA screening was completed when indicated. The MRSA screening audit for the period of October 2022 showed 95% compliance against the trust target of 100%. There was an action plan to address the areas for improvement required as a result of the audit.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas. We observed staff washing their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) *Infection prevention and control: QS61*).

From September to November 2022, the hand hygiene audit result showed 98.3% compliance for the maternity areas. From August to November 2022, the service achieved 93% compliance on the infection prevention and control audit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Access to the maternity service was by means of swipe card or an intercom buzzer system. The theatres, recovery, close observation unit, triage and antenatal ward were close to the labour ward which allowed timely transfer when required.

The labour wards and the ward areas required any visitors to be let in and out to maintain security. Security personnel were stationed in the maternity areas to ensure the safety of women and babies.

The design of the environment followed national guidance including the theatres and the corridors were clutter free. The service had suitable facilities to meet the needs of women's families.

There were two dedicated obstetric theatres in the maternity unit, which was in line with safe practice and had necessary equipment. The theatres were accessible 24 hours a day for an emergency caesarean section.

The unit had a specific bereavement suite located in a quieter area to support women and families who had experienced a baby loss.

There were arrangements to safely manage waste and dispose of clinical specimens in the service. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. We observed clinical waste was correctly segregated and changed frequently by staff during the inspection. All sharps bins inspected were assembled correctly, dated, signed and were not over full.

The service had enough suitable equipment to help them to safely care for women and babies.

All consumable items, such as emergency equipment, including syringes, medicines, airways and naso-gastric tubes all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag. However, staff did not always carry out daily safety checks of specialist equipment. There were gaps in daily checks of emergency equipment in the labour ward, birth centre and antenatal ward.

Three pieces of equipment across the maternity units were overdue service maintenance checks. In the antenatal clinic, we observed a urine analyser was due for servicing June 2022 and a transport incubator on the labour ward was due servicing August 2022. We also observed an ultrasound machine that was due for servicing in May 2021, which was escalated to staff during inspection.

Women could reach call bells and staff responded quickly when called. Call bells were available in every patient bathroom. However, some of the bathrooms observed were not ligature free which was highlighted to senior management. There was no environmental ligature risk assessment following the national patient safety alert on 3 March 2020. We were told a risk assessment would be carried out to address these concerns within a few days. However, the trust did not provide the environment risk assessment to the inspection team post inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff completed risk assessments for each woman on admission / arrival, and reviewed this regularly, including after any incident. The criteria for women planning to have their baby either at home, birth centre or labour ward were in line with national guidance.

Staff used a nationally recognised tool to identify women and babies at risk of deterioration and escalated them appropriately. The maternity service used the newborn early warning trigger and track tool (NEWTT) on the wards, to identify babies at risk of clinical deterioration following birth and initiate prompt investigation and intervention. The service also used the modified early obstetric warning score (MEOWS), designed to allow early recognition of deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. We saw evidence staff completed the MEOWS and NEWTT charts in the patient records reviewed.

Staff described how they would respond to a medical emergency, which was in line with the trust policy. Staff undertook skills and drills scenario training on a yearly basis. We observed staff respond calmly to an emergency call bell during inspection.

Maternity

Women who were at risk of gestational diabetes were referred to the diabetic clinic for a glucose tolerance test to monitor and assess their blood sugar to prevent gestational diabetes, hyperglycaemia (high blood sugar) or hypoglycaemia (low blood sugar). The findings of these risk assessments were used to help women choose their preferred place of birth and plan future care provision. Staff told us they had a high number of women, approximately 15%, who accessed the service diagnosed with gestational diabetes. The service offered regular group training for women diagnosed with gestational diabetes to equip them with the knowledge needed to manage their condition and minimise risk to themselves and their baby.

The consultants held regular high-risk obstetric clinics for women who had medical issues or conditions such as a high body mass index (BMI).

The service used a recognised triage assessment tool traffic light system to assess and prioritise women presenting to triage. Women classified as high risk were prioritised to be seen by the midwives and consultants for assessment and treatment. Staff told us the new triage traffic tool was an improvement in the service and was implemented in response to learning from recent serious incidents where investigation reports highlighted that women were not appropriately red, amber and green rated in the previous system used. Staff told us they now had two midwives and registrar cover to support implementation of the new triage tool. The increased staff was an improvement following a recommendation from a recent regional Ockenden assurance monitoring visit. Triage was previously staffed with one midwife.

The service had a buddy system for review of CTG interpretation, with guidance for escalation where concerns were noted. The system involved a second midwife checking a CTG recording of a baby's heart rate to ensure it had been interpreted correctly and actions taken when indicated. This was in line with national recommendations from NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth*. We observed senior midwifery staff used the central electronic fetal monitoring system to have a helicopter view of women on the units and to assess and discuss the fetal monitoring which was considered best practice. The CTG audit for the period of September to November 2022 showed an overall 74.3% compliance. We noted poor compliance for medical staff (68%) while midwives achieved 86.6% in that period. Action plans had been developed to improve compliance. As a result, the November 2022 audit showed a significant improvement and the overall compliance was 95%.

The unit had a dedicated telephone line for patients to call if they had any concerns or queries. The phone-line was put through to a member of triage staff to assess and advise the women accordingly. Notes from these conversations were recorded in the women's care record.

The service had 24-hour access to mental health liaison and a specialist perinatal mental health midwife if staff were concerned about a woman's mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. They used a structured communication tool known as Situation, Background, Assessment, Recommendation for communication between team members.

Staff monitored the baby's growth, and accurately plotted this. Staff generally identified babies that were not meeting their growth potential, as they would be at higher risk of complications. However, the service did not routinely carry out the 36 weeks scans unless there were concerns and there was a risk of missing late small gestation age and still birth. Senior managers told us the service had opted to use GAP and GROW tools rather than carrying out a 36 week growth

scan. The GAP/GROW surveillance tool was monitored on an annual basis. Two recent Healthcare Safety Investigation Branch (HSIB) investigations highlighted GROW scan and charts as areas for learning and advised the trust to align their guideline with national guidelines. The charts were also to be included as part of holistic risk assessment at each contact with women.

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

Midwifery Staffing

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

Managers accurately calculated and reviewed the number and grade of midwifery staff and maternity care assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of women. The service held three safety huddles daily to review staffing levels and midwife to service user ratio to ensure safe care.

The service used Birthrate Plus to monitor acuity and calculate midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives (RCM). Staffing levels were reviewed at daily handovers, 'Just 5' meeting and safety huddles. Any staff shortages identified were escalated to the director of midwifery, deputy head of midwifery, labour ward coordinators and matrons in charge. Safe staffing in maternity was regularly reported to the trust board. Staff knew their escalation process and how to escalate any staffing issues in the service. This was an improvement from the last inspection.

The July 2020 birth rate plus report highlighted the service had a shortfall of staff of 23.02WTE (Whole Time Equivalent). Shortfalls were mainly related to band 3 to 7 staff. The report recommended a midwife to women birth ratio of 1:21 instead of their current ratio of 1:24. Following the report, the service received Ockenden funding for additional 23.2 WTE midwifery staff, which increased their vacancy to 43.36WTE (29%). The service had used bank and agency staff to maintain a 1:21 midwife to woman ratio, which is considered gold standard. The agency and bank staff were paid an enhanced rate to ensure gaps in rotas were filled.

The service had enough nursing and midwifery staff on each shift to keep women and babies safe. The service used temporary staff or redeployed staff within the maternity unit when needed to ensure patient safety and prevent avoidable harm.

The service had high rates of agency midwives. Managers requested staff familiar with the service to cover gaps in the rota and staff sickness. Managers avoided using bank staff frequently to ensure staff did not get burnt out. The agency staff we saw during inspection had been working at the service for over 5 years. Managers made sure all bank and agency staff had a full induction and understood the service.

We reviewed the November 2022 safe staffing report which showed that the staffing levels for the month of October 2022 were green for over 66% of the shifts. There were no red-flags or serious incidents for the month of October 2022 where staffing contributed to concerns around safety or care and service delivery issues. For the period of September to November 2022, the average agency usage was 23.9 WTE and 7 WTE for bank usage.

Maternity

The number of midwives and maternity care assistants matched the planned numbers during inspection. The lead midwives and coordinators were extra during inspection. The service staffing levels was rated green during the safety huddles.

Managers made sure staff received specialist training for their role. There was a preceptorship programme for newly qualified midwives. Newly qualified midwives we spoke to talked highly of the preceptorship programme and told us they felt well supported, had good peer relationships and staff took the time to explain things.

The service had reducing vacancy rates. During inspection, the vacancy rate was 23%, which had reduced in recent months as the service had recently employed 12 midwives that were due to start in December 2022 and January 2023. This would reduce the vacancy rate to 15%. The labour ward and postnatal wards were the areas in the service which had vacancies. Turnover rate was high due to staff relocation, staff commute distance to work, high cost of living in Croydon and career progression.

In order to aid staff retention, the trust was in the process of implementing several initiatives. This included focussing on supporting student midwives, regular midwifery listening events to encourage speaking up and updating staff on recruitment progress and international recruitment.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* 2007). For the period of April to October 2022, 98% of women received one to one care during active labour against the trust target of 100%.

Although managers supported staff to develop through yearly constructive appraisals of their work, appraisal rates were low. Data supplied by the trust during the inspection showed appraisals completed for maternity staff was 64%. This was not an improvement from the last inspection. The interim managers were working with the service leaders to book all outstanding appraisals. The low compliance was mainly related to staff sickness and staffing pressures. Staff we spoke to during inspection have had their appraisal or were due their appraisal in less than two months.

The maternity service had not closed in 2022, however, the birth centre had been closed 50% of the time due to deployment of staff to other maternity areas and women in labour were cared for on the labour ward. This was mostly related to the demand for the service. Staff told this had not impacted on patient care.

The service had a cohort of 102 student midwives from various universities. Senior managers told us the high number of students was as a result of pressures on NHS hospital to take more students. The service had risk assessed the high number of students to ensure students were well supported. The service had increased the number of practice educators to 2 and the number of clinical practice facilitators to support and revamp the student and preceptee programme. Senior staff felt the student midwives were able to observe the number of births and complex cases needed to sign off their competencies, such as personally carrying out a minimum of 40 deliveries before getting qualified. Data received from the trust showed that student midwives who graduated last year were able to achieve their proficiencies, however 50% had to stay for an extended period to achieve the required 40 deliveries. Student midwives we spoke to felt well supported and told us staff were helpful in teaching and supporting them during clinical placements.

Medical staffing

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

Maternity

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants were on site 8.30am to 11pm and on-call 11pm to 8.30am, 7 days a week. The service always had a consultant on call during evenings and weekends. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Data supplied by the trust showed there were 15 WTE consultant obstetricians, 11 WTE consultant anaesthetists, 8.46 WTE specialist trainees, 6 clinical fellows and 10 senior house officers (SHO) working in the maternity unit as of 30 November 2022.

The maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward. The service also had a dedicated registrar covering the antenatal ward, triage and day assessment unit from 8am to 5pm Monday to Friday. There was an on-call registrar that covered triage and the antenatal ward outside these hours.

The maternity service MDT worked together with external partners such as GPs, social workers, the Home Office, health visitors and other hospitals to improve patient care and outcomes. Doctors, midwives, midwifery support workers, safeguarding midwives, perinatal mental health midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women's care and treatment.

MDT staff held regular and effective multidisciplinary meetings to discuss and improve the provision of care to women using the service. Daily safety huddles, ward rounds and handover meetings took place to update staff on plans for women and babies. MDT staff spoke highly of each other and the focus on collaborative care to improve care and patient outcomes.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The maternity service used paper and electronic records to document women's care and treatment. Electronic records were used during the intrapartum period. Staff had received training to use the electronic records. The service was planning on going paperless in the next 18 months. At the time of inspection, a pilot of the new electronic record system was ongoing in the community. The service was also planning to integrate the intrapartum CTGs into the current electronic system.

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

Women's notes were comprehensive, and all staff could access them easily. Records were stored securely. When women transferred to a new team, there were no delays in staff accessing their records. We reviewed 5 records for women at different stages of the maternity pathway and found records were comprehensive. All risk assessments and clinical assessments were complete. However, staff did not always indicate when CTG (fetal heart monitoring) was started or completed in 2 of the 5 records reviewed.

Regular clinical assessments by the multi-disciplinary team (MDT) such as the physiotherapist were evident in the maternity records we reviewed. Discharge summaries were sent to health visitors and GPs.

Maternity

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored and managed appropriately.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were stored in locked cupboards and staff used a keypad entry system to access the clinical rooms were medicines were stored. We noted that only relevant clinical staff could access the medicines in the clinical room or locked cupboard.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services.

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely. The medicines and controlled drugs reviewed across the maternity wards were all in date and arranged in a neat and organised manner.

There were effective processes for managing medicines, including controlled drugs (CDs) and emergency medicines. CDs were checked twice daily by 2 midwives. Controlled drugs were stored and managed appropriately. Medicines reconciliation was completed and recorded where any discrepancies were actioned.

We found medical gas cylinders used in the maternity areas were stored appropriately in a locked room, in line with national guidance. Oxygen cylinders were full and within date.

There were arrangements to ensure adequate supplies of emergency medicines and equipment was available, including out of hours. The service had several trolleys where emergency medicines were stored such as the resuscitation trollies for adults, paediatrics and neonates. Other trolleys where medicines were stored included the postpartum haemorrhage (PPH), epidural and hypoglycaemia. We noted that all emergency medicines were all in date.

Medicines fridge temperatures were not always checked daily in all clinical areas. For example, we reviewed the medicines fridge temperature record for January to December 2022 on the labour ward and noted there were 58 omissions during this period. We saw evidence were fridge temperature was out of expected range. This was reported and actioned appropriately by staff.

Some medicines were not stored appropriately in original packaging. For example, in triage and the birth centre, we observed single sheets of different medicines were stored outside of original packaging and kept in a plastic bowl. In the immunisation clinic, we observed flu vaccines were stored out of original packaging. We also observed two oral medicines; peptac and morphine on the postnatal ward which had been opened and did not have a label stating when they were opened.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, not all staff were familiar with recent reported incidents.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Managers investigated incidents thoroughly. Women and their families were involved in these investigations.

Staff reported serious incidents (SIs) clearly and in line with trust policy. From January to December 2022, the service reported 15 SIs in the service of which 7 were related to HSIB investigations and mostly related to intrapartum, still birth and baby cooling. The top recommendations from the HSIB reports were mainly related to risk assessment, clinical assessment, family communication, fetal monitoring and clinical guidance.

The service carried out a maternity SIs thematic review in June 2022 to review SIs which occurred between April 2021 and March 2022 following concerns raised by staff. The report showed 20 SIs were reported and 4 were reviewed internally and 16 were external HSIB reviews. The themes from the SIs were related to CTG, appointment and result, GROW charts and ultrasound scanning, communication, escalation and documentation and lack of senior review or face to face review. Senior staff told us the review highlighted the SIs had been investigated appropriately and the review had provided assurance in their incident review process.

Managers debriefed and supported staff after any serious incident. Managers shared learning with their staff about never events and external national maternity reports that happened elsewhere. Some staff were not aware of recent serious incidents and learning, despite, learning from incidents being shared at weekly maternity newsletter, governance newsletter and emails. Senior staff including the governance and risk team told us there were on-going work being done to identify better ways of sharing learning from incidents with staff.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Managers monitored the service compliance to the duty of candour. Staff felt they were good at listening to women and concerns whilst not being defensive and had open conversations with women when things went wrong.

There was evidence that changes had been made as a result of feedback. Following a serious incident investigation, the hospital had developed a day assessment unit guideline which include information for staff on steps to take when mothers did not attend appointment.

All still births and neonatal deaths were investigated and reported to the MBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) in line with the national guidance. From April to October 2022, the service reported 4 neonatal deaths in the service. The service used the MBRACE tool kit to review perinatal mortality. MDT staff reviewed and discussed patient deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated well-led as good because:

Leadership

Maternity

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

There was a clearly defined management and leadership structure. The maternity service was under the Integrated Women, Children and Sexual Health directorate. The maternity leadership team consisted of a clinical director, head of midwifery, Director of nursing and midwifery and associate director of midwifery. The maternity leadership team were supported daily by general and operational managers, matrons, consultant midwife, specialist midwives and lead clinicians.

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The service leaders told us they had good direct access to the chief executive and this worked very well. We saw from the minutes of board meetings that the trust board had oversight of the maternity service and received presentations on the maternity service. Staff knew who their leaders were.

The trust had a non-executive director (NED) with responsibility as maternity safety champion. We spoke with the NED, who seemed knowledgeable about the problems facing the service, notably those related to recruiting, retention, and ensuring that women's perspectives were promoted. The maternity safety champions meeting minutes showed a healthy discussion regarding safety issues, performance and feedback.

Managers completed regular walk arounds. Staff found them approachable, and keen to hear their views and experiences to drive improvement. The director of midwifery chaired the 'Just 5' meetings which had helped improved communication and feedback. Staff felt the 'Just 5' meeting was a "game changer" and had helped with visibility and accessibility with senior leads to aid discussion around issues in the service. Staff told us their senior leaders were "great" and "supportive".

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a trust wide strategy and vision. The vision was focused around 'excellent care for all and helping people in Croydon live healthier lives'. The trust values were to be professional, compassionate, respectful and safe.

The strategy was centred around 5 core strategic objectives, which were; improve health and reduce inequalities, high quality care, support our staff, sustainable finances and develop our leadership. The trust strategy was being reviewed at the time of inspection and the maternity strategy was being developed to align with the new trust strategy.

The current maternity strategy was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby Counts and national NHS maternity five-year strategy around better births, continuity of care and national

recommendations. The strategy focused on reducing health inequalities, continuity of care, staffing, technology, safety and delivering national recommendations such as recommendations from the Ockenden report. The service had liaised with staff and maternity voice partnership (MVP) in developing the maternity strategy. There was a working group leading on the various strategic objectives.

The managers worked and engaged actively with the MVP and providers in the local maternity networks system (LMNS) region in improving neonatal and maternal pathways, outcomes and provision as laid out in Better Births, Saving Babies' Lives and Maternal and Neonatal Health Safety Collaborative.

Culture

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

Staff were enthusiastic and passionate about their role and difference they made to the experience of women and their families. All staff had a strong commitment to their job, were proud of the team working, inclusivity, continuity of care, diversity in the population and positive impact to patient care and experience.

Staff including the senior managers were proud of the maternity service. Staff were proud the service was able to have sustained and not disbanded the 5 continuity of care teams to support the complex and vulnerable women in their population due to staffing pressures.

The multi-disciplinary team (MDT) staff described good teamwork within the maternity service and directorate and gave examples of good team working and support on the wards between staff of different disciplines and grades. Staff told us there was good staff morale in the service, they were treated as equal and there was no hierarchy in how they were treated as part of the MDT staff.

Staff told us they supported each other on the shop floor and managers tried to ensure staff had their breaks by coming out of their office to support them on the wards in the delivery of care of women. Staff told us that sometimes when they had a busy shift, leaders had brought free food, which helped boost their morale.

The trust celebrated staff and team successes and supported good staff practice through a thank you initiative system, 'Croydon stars awards' and 'Croydon care awards'.

The trust had a freedom to speak up guardian who regularly visited the maternity areas. Details of the speak up guardian were displayed on posters across the hospital. Staff told us they knew their guardians and felt able to raise a concern with their managers. They told us the service took patient safety concerns and feedback seriously. We saw evidence of thematic reviews undertaken following concern feedback raised by staff to drive improvement and assurance on their processes.

Several junior and senior staff had been working at the trust for years. Staff felt there were opportunities to progress and be promoted and we saw evidence of progression of staff to senior roles since they have been employed in the service.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women

received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. From April to September 2022 the hospital received 17 complaints in relation to the maternity service. These were mostly relating to communication, patient care and staff attitude.

Health Education England (HEE) initiated an interventions review of the maternity service in response to the feedback from the trainee doctors and student midwives in the General Medical Council national training survey (GMC NTS) 2022 audit and HEE National Education and Training Survey (NETS) (June 2021). The findings showed several areas that were working well, for example, good medical trainee clinical supervision and training experience and excellent support received by the student midwives. Areas of improvement included, but not limited to, student midwives should have the opportunity to meet the medical team during orientation and induction and medical trainees should be aware of skills and drills taking place in the service whilst not on placement. The latest HEE NETS November 2021 audit did not find any negative findings from student midwives around induction and team working.

Governance

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

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service had a governance and risk team which supported staff and managers on managing the governance process and performance in the service.

The maternity service sought assurance through various governance meetings and reports, directorate meetings and trust board meetings. Meeting agendas included discussion around all aspects of governance and oversight of the service. Governance meetings were well attended with full multidisciplinary attendance from the minutes reviewed, and actions were highlighted and reviewed at each meeting. Outcome of governance meetings and service dashboard were shared with staff through emails, newsletters and posters.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. Improvement is checked and monitored. Managers and staff used the results to improve women's outcomes.

The directorate had an audit tracker where national and local audits due to be carried out were monitored. We noted that national audits relating to maternity were carried out within the deadline however 2 of the 8 local audits were overdue. This relates to the 2021/2022 stillbirth audit and cervical ripening and induction of labour. The service had recently employed an audit midwife who would be responsible for ensuring audits, policies and guidelines were carried out in a timely manner.

The service participated in relevant national clinical audits. Outcomes for women were a combination of positive, negative and partially met on some local and national standards. For example, data showed the service met the trust target on 4 of the 6 screening standards audited. The hospital participated in the MBBRACE 2020 audit and performed similar to the group average for all births and for births excluding congenital anomalies. The service also met five of the six standards in the saving babies lives care bundle action plan.

Maternity

The service was meeting the trust target on the number of babies born before arrival, shoulder dystocia and still birth rate. The service was not meeting the trust target for the avoidable repeat bloodspots screening, failed instrumental delivery and the number of women smoking at delivery and discharge. The service had action plans in place to improve performance and outcomes for women.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Not all policies and guidelines were in date and reviewed. We looked at 23 maternity policies and guidelines, of which 8 were overdue for review. For example, the admission to the maternity unit policy was overdue for review since June 2022 and the newborn blood spot screening guideline was due for review since December 2021. Staff including senior managers were aware of this issue as a result of staff sickness and had plans to address this. Staff told us that the 8 policies and guidelines that were out of date were allocated to senior medical and midwifery staff the week prior to our inspection for review. Also, the recruitment of the new audit and quality midwife due to resume her role in 19 December 2022 would ensure any overdue or soon to review policies and guidelines were allocated to the appropriate staff in a timely manner for review.

Management of risk, issues and performance

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

The service had effective systems and processes to identify and manage risk in the first instance. The maternity service had a risk register which included 8 risks such as staffing, high vacancy rate, patient record and access and flow in triage. The risk register had risk owners, was dated, included the initial risk grading, the current risk and target risk grading, risk controls and mitigations and next review date. We noted the risks were reviewed regularly, and actions were put in place to reduce the risk.

The maternity service had achieved the UNICEF baby friendly level 2 status and was working toward achieving the level 3 status.

Information Management

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

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. Performance results were discussed at divisional and board level to improve care and patient outcome. Audits and performance data were displayed on the wards for staff, women and visitors to access.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme, maternity dashboard, friends and family test (FFT) results and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Maternity

During inspection we observed staff protect patient identifiable information in line with General Data Protection Regulations (GDPR).

The service had employed a digital midwife that was responsible for leading changes and improvement on digitising records and ensuring information systems were fit for purpose and data was accurate.

Engagement

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

The service obtained and acted on people's views and experiences to shape and improve the services and their experience. We saw evidence that service user feedback was sought to inform changes and improvements to service provision during and after the COVID-19 pandemic.

The service had engaged with black, Asian and minority ethnic (BAME)women and staff to obtain their experience in working in the maternity service in England during Covid and beyond.

The maternity service had a functioning Maternity Voices Partnership (MVP) which met regularly and was active in the service planning and delivery, walk arounds of maternity areas, reviewing and monitoring national maternity recommendations, review of trust maternity website information, co-producing information leaflets. The MVP had plans to recruit more service users in order to help reach the harder to reach communities through outreach work. The service recognised more work was still required in translating some leaflets in other languages spoken by women in their population and the MVP were involved in this project.

Local and senior managers were visible on the ward, which provided patients and staff with the opportunity to express their views and opinions.

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

The service regularly presented a patient experience summary report and patient survey findings to the board. The service also engaged with staff, women and the public through social media and the maternity page on the hospital website.

Managers engaged with staff through various staff meetings, 'Just 5' minutes', staff forums, listening events and newsletters. For example, newsletters from the last 8 months included items such as shout-outs to new staff and students, names and pictures of the maternity management team, listening events, renovations due to take place in the service, the staff survey, patient feedback, trainings and simulations, walk the patch findings and shout outs to preceptee or student midwives that have finished their programme.

Staff displayed letters and thank you cards of positive feedback about the service on the noticeboards. We saw several thank you cards across the maternity areas from women and their families. Example of specific feedback included, "it was a traumatic experience but I am grateful for the patient and compassionate staff that helped me get through", " without your words of encouragement my whole experience could have been so different, so I can't thank you enough for all of your help and advice".

Maternity

The service engaged with other services including local charities to deliver continuity of care and create networks for women living in deprived areas and those whose first language was not English, such as the Urdu population. Staff also worked with local charities to provide nappies and clothes for women and babies.

The service worked closely with the home office and social services to cater for women and their families that were homeless or asylum seekers.

Learning, continuous improvement and innovation

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

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

Staff working for the service had been recognised for their skills and contribution to the maternity service. For example, the director of midwifery for assurance had received a Health Service Journal (HSJ) race equality award for being part of the group who produced the 'Turning The Tide' report. The non-executive maternity safety champion had received a special recognition global health award, for work undertaken relating to reducing women's health inequalities. A specialist midwife had received a British Journal of Midwifery award for midwife of the year. The service was awarded the national chief midwifery officer gold award for outstanding services in midwifery.

Midwives in the service launched the Health Equity and Racial Disparity (HEARD) campaign during the COVID-19 pandemic in 2020 to raise awareness and have difficult conversations around health inequality and racial disparity within maternity for the Black, Asian or any other minority ethnic group. The campaign aimed to reduce the impact of some issues which could potentially contribute to increased risk in these group of women as well as improve the experience and health outcomes. Staff told us the campaign was also rolled out to staff to open conversation around their experience and expand on their awareness of the 'fiveXmore' movement which highlighted different maternity outcomes based on ethnicity. The service also launched a dedicated phone line for women, including those that may be affected by the HEARD campaign and those who needed to be heard. The service carried out a HEARD campaign survey in November 2022 to receive feedback from vulnerable women about how they felt about the care received. The feedback received was positive and women felt midwives were caring and supportive, listened to their complaints and concerns, felt seen and heard and staff were kind, lovely and professional.

Outstanding practice

We found the following outstanding practice:

- The HEARD campaign launched during the COVID pandemic to raise awareness and have difficult conversation around health equity and racial disparity within maternity for the black, Asian or any other minority ethnic group with the aim to improve outcome were exemplary.

Maternity

Areas for improvement

Action the trust SHOULD take:

- The trust should ensure that staff have completed the GAP and GROW training.
- The trust should ensure equipment including emergency equipment are regularly maintained and checked in line with trust policy.
- The trust should ensure medicines are stored and managed appropriately, and medicines fridge temperatures were monitored and recorded in line with the trust requirements.
- The trust should continue to address the high vacancy and turnover rates in maternity staffing.
- The trust should ensure staff receive an annual appraisal.
- The trust should review the number of student midwives in the maternity service and ensure there were no delays in the completion of student midwives' proficiencies.
- The trust should ensure policies, guidelines and procedures are reviewed and follow national guidance.
- The trust should ensure an environmental risk assessment is carried in all maternity areas and emergency call bells are ligature free.

Our inspection team

The team that inspected the service on the 6 & 7 December comprised a CQC lead inspector, three other CQC inspectors and three specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.