Homerton Healthcare NHS Foundation Trust

Homerton University Hospital

Inspection report

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Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good** ●
Are services well-led?	**Outstanding** ☆

Our findings

Overall summary of services at Homerton University Hospital

Outstanding ☆ ➔➔

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 Homerton University Hospital.

We inspected the maternity service at Homerton 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 an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Homerton University Hospital is part of Homerton University Hospital NHS Foundation Trust; the trust serves a diverse and complex local population from Hackney, the City of London, and surrounding boroughs in East London. The hospital provides maternity care for approximately 6000 women and their babies each year during pregnancy, labour, birth and up until one month after birth.

A higher proportion of mothers were in the 2nd and 3rd most deprived deciles at booking compared to the national averages. The proportion of women and birthing people who were Asian or Asian British was 13% which was lower than compared to the national average and also lower for women and birthing people who were White at 50% compared to 66% nationally. Women and birthing people who were Black or Black British was higher at 13% compared to 7% nationally.

We did not review the rating for Homerton University Hospital. However, we did update the ratings for maternity services.

Maternity

Good ➔➔

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

- Midwifery staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

- The initial triage assessment timeframe expectations were not always met and there were delays in medical reviews.
- Medical staff multi-professional simulated training did not meet trust targets.
- The telephone triage system at busy times did not always support the needs of women and birthing people.
- National guidance was not always followed for continuous electronic fetal monitoring for using 'fresh eyes' assurance.
- The service had challenges with recruitment which reflected the current national shortage of midwives and medical staff. Staffing levels did not always match the planned numbers. Consequently, some women and birthing people felt unsupported during the postnatal period on the ward. Although, managers always reviewed staffing levels to mitigate risk.

How we carried out the inspection

During the inspection we visited and inspected the maternity triage, emergency obstetric unit (EOU), labour ward, the birth centre and the ante and postnatal wards. We spoke to 18 members of staff, reviewed 8 sets of digital care records and 10 standard operating procedures. After the inspection we spoke to the maternity leadership team, the maternity safety champions, and the local Maternity Voices Partnership (MVP).

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.

Is the service safe?

Requires Improvement ➔➔

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

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and had systems to ensure everyone completed it. Both mandatory and additional obstetric training was provided and most staff completed it within trust targets.

Service leaders had implemented a training needs analysis in 2021 to make sure there was a systematic approach to specialist training for all staff providing care for mothers and babies. The education team booked staff on to a week's internal maternity training programme.

The education team comprised of a clinical placement facilitator, who was supported by 4 practice development midwives.

Midwifery staff received and kept up to date with their midwifery mandatory training. Records for June 2023 showed training exceeded the trusts 90% target, 92% of midwives had completed mandatory training. Also, 97% of midwives had completed their manual handling and pool evacuation training.

However, compliance for additional maternity training, which included but was not limited to, blood spot screening, antenatal screening, improving patient safety and learning from incidents was 72% in June 2023.

Medical staff received and kept up to date with their mandatory training. Data showed that 100% of consultants and 90% of medical staff had completed most aspects of their trust wide mandatory training courses, which included adult life support, fire safety and infection prevention control.

The service did not always ensure that staff received multi-professional simulated obstetric emergency training. Records from April to June 2023 showed that midwifery compliance for this training was 81%, and consultant compliance was 68% and medical staff compliance was 58%. Staff told us this was in part due to the records system not capturing data and also due to a lack of capacity for training in consultant job plans. Following inspection, the trust told us all junior doctors starting work in the department attend training within their first 3 months, and the way training records were kept had been updated. There was a plan for consultant PROMPT training for the rest of the year.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Records showed that 97% of consultants, 94% of midwives and 95% of medical staff had completed this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Maternity support workers did not all keep up with their mandatory training. Records showed that their compliance for most aspects of the 13 mandatory courses fell below trust targets and averaged 82%. Leaders told us this was because there were shortfalls in support worker staffing which meant they did not have time to complete all aspects of training.

Safeguarding

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

Maternity

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 94% of midwives and consultants and 92% of other medical staff had completedsafeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Safeguarding training included modules on perinatal mental health, domestic abuse, child exploitation and substance misuse. The service worked closely with safeguarding teams at the local authority to deliver face to face level 3 training and included 8 modules with in depth discussions during the training sessions.

A named midwife for safeguarding worked closely with a specialist midwife for perinatal mental health. The safeguarding lead offered safeguarding supervision to midwives. The safeguarding lead, perinatal mental health midwife and 7 public health midwives had restorative supervision provided by an external 3rd party clinical counsellor who also offered all staff 1:1 support.

Also, they made sure they visited the wards every day so that they had oversight of current safeguarding concerns and to support staff.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward. Only children who were siblings of the newborn were able to visit the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored, and posters were on display to remind people about ‘tailgating’. The service had practised what would happen if a baby were abducted within the 12 months before inspection.

The service had a quality improvement project for women who have their babies removed at birth, this was in conjunction with birth companions and the ‘Pause Project’. When babies were separated from their mothers, mothers were given a hope box, which contained information on the birth, hand prints of the baby and a diary for the mother to record her thoughts in for her baby. The project will contribute to a larger project which will focus on trauma informed care to make sure women and families understand the process, and can access support so that they can start to rebuild their lives again.

Maternity

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Housekeepers completed general cleaning in all areas, and midwives and maternity support workers were responsible for cleaning bodily fluids. Antimicrobial hand gel was provided at all ward entry points, housekeepers were responsible for the basic ward cleaning. Domestic service staff were available 24 hours a day via a Helpdesk. Staff told us that during the night housekeeping staffing was minimal, which meant clinical staff had to clean labour rooms after childbirth. This had a knock-on effect on patient facing care.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service performed well for cleanliness. Staff completed monthly environmental cleaning audits which included but not limited to equipment, furnishings, curtains, environmental and hand washing facilities. The audit data showed that the service had oversight of each aspect of infection control and in general the scores averaged 99%.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust had lifted mask wearing restrictions, so that mask wearing for staff was optional. Hand gel was available at every entrance and receptionists monitored staff and visitors to make sure they used the gel when entering the wards. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 98%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use because ‘I am clean’ stickers were added to clean equipment.

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.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment did not follow national guidance in all areas. The hospital was built in the 1980’s and although ward areas were spacious there was limited room for staff offices or break rooms. There were 14 labour rooms and 2 enhanced care beds on delivery suite, and 4 labour rooms on the birth centre. The ante and postnatal ward was combined and housed 6 bedded bays, one was used for antenatal care and was spacious and light. The postnatal area comprised of 4 6 bedded bays and side rooms. On the day of the inspection the ward was full, so staff used the birth centre as an overflow for postnatal care; during our visit we saw 2 women/birthing people housed in each birth room. The maternity unit was fully secure with a monitored entry and exit system.

Maternity

The emergency obstetric theatre on labour ward was smaller than the main theatres. Staff told us this theatre met the basic size standards. However, service leaders chose to host elective caesarean sections in the large obstetric theatres and emergency procedures were carried out in the adjacent main theatres. The trust was reviewing the layout of the obstetric theatres and had completed an audit on the average number of emergencies they had each week to ensure that both were suitable for all kinds of obstetric theatres.

On the day of the inspection, we noted that the theatre corridor was used to store mobile equipment which meant it reduced the corridor width. We raised this as an evacuation and infection prevention control concern with leaders who responded quickly and completed a risk assessment of the area and removed some equipment and checked for cleanliness, the risk assessment assured us that leaders had oversight of the management of the area.

Ward huddles occurred in the clean utility room on the labour and postnatal wards.. The labour ward had a handover board, but the postnatal ward did not. Although patient confidentiality was maintained, leaders agreed it was not ideal to use these rooms for huddles from a space point of view and told us there were plans underway to make an improvement.

Staff carried out daily safety checks of specialist equipment. The service had an 'Electrical Safety Policy' to support the safe management, design, and installation of electrical equipment. The estates team were responsible for the management of portable electrical testing (PAT) inspections and equipment displayed stickers of when PAT testing had occurred. Records showed that all equipment had been tested within the last year and that resuscitation equipment outside maternity theatres was checked daily. The May to June 2023 resuscitaire checklist audits showed staff checked 99% of resuscitaires at every shift against a trust target of 100%.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

The service had introduced a 'Ligature risk management for Maternity Environment' standard operating procedure this year to keep patients with mental health needs as safe as possible by minimising the risk of self-harm or suicide from ligatures within the department. People identified as high risk were admitted to 'ligature free' rooms and closely monitored by staff.

The design and layout of rooms used to care for mothers and families who had experienced a bereavement did not reflect national recommendations from the 'Sands' bereavement charity which states 'The room should be equipped with a double bed, en-suite bathroom, and small kitchen area wherever possible. This is to enable parents to spend time in the room with their baby and any visitors'. The room used at Homerton University Hospital was placed in a quiet area of delivery suite, and on the day of the inspection it was being used to care for a lady waiting for a planned caesarean

section because of lack of space. The room had minimal medical equipment, gentle lighting, and comfortable chairs for partners and family to visit. There was a cupboard with tea and coffee and mugs for patients to have easy access. However, it did not house a double bed, neither did it look like a home from home setting. Records from managers showed that they had acknowledged that the service needed an additional room to safely care for bereaved families.

Assessing and responding to risk

Staff mostly completed and updated risk assessments and took action to remove or minimise risks most of the time. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools to assess and monitor women and birthing people during the antenatal period.

Staff risk assessed women and birthing people at their booking appointment (first full risk assessment at the beginning of pregnancy) and used the five elements of the 'Saving Babies Lives Care Bundle version 2' which are:

- Reducing smoking in pregnancy
- Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction
- Raising awareness about fetal movements
- Effective monitoring of fetal monitoring during labour
- Reducing preterm birth

However, audit data showed that the service needed to improve completion of carbon monoxide (CO) risk assessments at 36 weeks of pregnancy and in the postnatal period.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. In maternity triage and the emergency obstetric unit, staff followed the local 'Maternity Triage Guideline' which informed staff and included assessment cards of the most common complications of pregnancy. Staff used a colour coded prioritisation score to identify high risk women and birthing people. The red, orange, yellow, green rated system showed expect review times for people who presented to triage. For example, those women most at risk were seen immediately and sent to labour ward. Staff reviewed those people who scored orange within 15 minutes and those people who scored yellow were identified to be seen within one hour.

There was a joint obstetric and diabetes clinic between consultant obstetricians and an endocrinologist, who would also review people on the maternity wards, and a diabetic lead midwife. Diabetes nurses were also available for reviews.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The maternity triage waiting times for review audit for September 2022 to February 2023 included monitoring of initial wait times, correct categorisation, time to next midwife assessment and time to medical review. The audit showed midwives reviewed 68% of women and birthing people within 15 minutes of arrival and that midwives correctly categorised people 87% of the time. However, only 67% of people received their medical review within the expected time frames. Managers monitored wait times and identified that delays occurred for the lower risk categories. The service had a maternity helpline service. Antenatal patients requiring advice or care called the maternity helpline between 10am to 6pm, 7 days a week. Out of these hours,

calls were signposted to the Maternity Emergency Obstetric Unit. Contact details were on the back of the paper maternity care records provided at booking. Since February 2022 staff documented telephone calls on the electronic patient record using a telephone call proforma. Service leaders told us this telephone triage service was funded with 2.89 WTE. There was a business case they had submitted to expand the maternity helpline to improve the service; this would reduce delays in call answering during busy periods.

Staff knew about and dealt with any specific risk issues Staff reviewed blood screening and scan results to help inform decisions around care and staff members were responsible for checking their own results.

Staff used a formal process to assess women admitted for an induction of labour. Staff gave women and birthing people a pre induction information leaflet to prepare them for the induction process.

Staff followed a sepsis care bundle for when women's MEOWS scores triggered alerts. Ward areas contained an emergency sepsis trolley which was locked with a key code and contained flow charts and equipment to actively treat those women at risk of sepsis. The maternity dashboard for April 2022 to March 2023 showed that there were 79 cases of sepsis with two clusters in November and December 2022. This information is important to inform infection prevention control and public health awareness.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Managers completed a monthly 'Maternity: Compliance Rounding Inspection Summary' which included reviews of compliance to completing MEOWs correctly. We reviewed 8 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Records from May 2022 to April 2023 showed that the compliance average was 90% and the trust had set a target of 95%. Managers shared learning from compliance outcomes and there were staff reminders on notice boards and via handovers for staff to complete all aspects of MEOWS.

Some midwives were trained to care for the critically ill woman/person during labour and immediately after birth in the 2 bedded enhanced maternity care unit which was on labour ward and located near to theatres, the rooms were equipped with additional equipment for intensive monitoring and staff working in the rooms followed clear care pathways for various common conditions, like eclampsia, massive obstetric haemorrhage, cardiac conditions and Covid 19.

However, not all staff used the fresh eyes approach in line with National Institute of Care and Excellence (NICE 2022) Fetal monitoring in Labour guidance, 1.2.1 states: Obtain an in-person review of every hourly assessment (see recommendation 1.3.5) by another clinician ("fresh eyes") for women on CTG, to be completed before the next assessment takes place. Instead, the local continuous electronic fetal monitoring policy advised staff to use fresh eyes "as often and as promptly as you feel necessary and a maximum interval of every 2 hours" and this was reflected in posters displayed on labour ward. Staff told us the midwife looking after the women and birthing people checked the CTG and documented this every hour, however a fresh eyes review by a peer took place every 2 hours.

Leaders completed quarterly continuous cardiotocograph (CTG) compliance audits to improve compliance to recording information on CTG records. Records showed that compliance to hourly reviews by staff caring for patients was 68% and that 'fresh eyes' at every 2 hours was completed in 63% of cases. Because of the gaps in documentation and fresh eyes leaders had recently implemented monthly audits and reminded staff via the safety huddle, team meetings and spot checks.

The service had a 2-bed enhanced maternity care unit on labour ward located near to theatres. This meant the service could care for women and birthing people who required greater monitoring and input.

Maternity

Doctors and a lead midwife planned care for women and people who wanted to give birth outside of national guidelines. Staff uploaded complex birth plans to the electronic records system, so they were available on labour ward and circulated to all obstetric and anaesthetic consultants as well.

The anaesthetic team ran a high-risk clinic 4 times a month, and a separate clinic for people with a raised body mass index.

In theatres staff used Local Safety Standard for Invasive Procedures (LocSSIPs) which was introduced at Homerton University Hospital in 2022, which replaced the WHO Safer Surgery Checklists within the trust to deliver safe care for patients and includes: All maternity patients should have the following: -

1. Team Brief (ELCS only).

2. Sign In - prior to anaesthesia.

3. Time Out - prior to starting procedure.

4. Sign Out - prior to leaving theatre.

5. Debrief.

Staff followed a theatre check in process and a time out check in theatre for an elective case, both of which included the expected information. Staff used a laminated sheet based on a LOCSSIP to go through the time out check.

Managers completed compliance audits and the most recent audit January to April 2023 which looked at 50 sets of patient records showed that 100% of completed the first 4 aspects of the process. However, debrief was not recorded anywhere, because of this managers introduced recommendations to make sure that staff completed the debrief aspect of the standard which included the introduction of a training video due to be introduced in July.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. There was a psychiatry team on site for acute mental health support 24 hours a day and 7 days a week.

The service had links to the nearby mother and baby unit (MBU) (specialist unit caring for birthing people and new mothers experiencing severe mental health crisis) and engaged in joint multidisciplinary team (MDT) working with the MBU. Staff told us that all women and birthing people transferred from this unit to labour ward were accompanied by a registered mental health nurse providing 1 to 1 care in addition to their midwife. Managers on the ward made sure they provided around the clock monitoring for women with severe mental health issues.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The service had robust perinatal mental health systems that included a perinatal mental health team that included a specialist midwife, a lead obstetric consultant, a psychiatrist, and a psychologist. Staff told us complex care plans were circulated to all band 7 midwives and coordinators and were available on the electronic patient record, with escalation points for women and birthing people with mental health needs to get additional support.

In addition, the service had a learning disabilities and 'Vulnerable Woman' care pathway which was currently under review and used a multi-disciplinary approach to plan care for women experience mental health crisis during pregnancy, and in the postnatal period.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used a nationally recognised system called the 'SBAR (Situation Background Assessment and Recommendation) tool' prior to handing over care between transfers to different wards. However, midwives documented handover in various places for example on the electronic patient record, the yellow baby record, and a paper copy of the SBAR handover form. Managers monitored compliance, records from March 23- May 23 records showed that staff rarely completed paper SBAR records correctly with only 5% of records fully completed. Audits showed that staff updated the electronic patient care record after each episode of care to ensure key information was shared. Because the paper SBAR tool was not used correctly managers recommended the following:

1. Staff to record SBAR information on the electronic patient record and feed into the ward handover form.
2. The Templar ward electronic SBAR handover template should be amended to specifically contain prompts for the following items to be included in handover:

1. ■ Neonatal Early Warning Treatment Trigger (NEWTT) – risk and time next due
2. ■ Results – Blood results and GBS status
3. ■ Bladder care – timing of 1st void
4. ■ Drug chart review

Managers made sure staff received email alerts about the discontinuation and amended the electronic SBAR handover tool to add the items listed above and a new audit was planned for September 2023.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Safety huddles occurred at shift changes. The morning 'huddle' meeting on labour ward was led by the night shift coordinator. This included information on activity over the shift, the status and capacity of the different areas of the service, emergency and elective cases including the days planned induction of labours, medical and midwifery staffing, and messages of the week. The coordinator used a proforma to guide the huddle, which included prompts on safeguarding concerns and bereavements. Key staff from the night and day staff attended, however there was no sign in sheet to record which staff had attended, which does not reflect national recommendations.

Medical staff completed one to one ward rounds after handover and staff shared key information at handovers to keep women and birthing people and babies safe. Each member of staff had an up-to- date handover sheet with key information about women and birthing people.

The medical team and labour ward coordinator reviewed the board of women and birthing people in the afternoon to get an up to date status of the activity for labour ward and theatre.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff used a 'Newborn Early Warning Trigger & Track (NEWTT) system, to plot physiological observations after birth. The trigger was started if a babies observations were outside of normal range. However, managers told us that staff did not always complete all aspects of the trigger. Because of this, leaders implemented an action plan and reminded staff to complete the tool as per protocols and managers continued to monitor compliance. Audits from March to April 2023 records showed improvements to compliance, staff completed the tool correctly 92% of the time.

Maternity

The service did not provide a transitional care facility for babies who required additional care. This had been highlighted to the board during national compliance reviews as a risk to be addressed. Staff told us that babies who required additional postnatal antibiotics or screening tests had to be taken by their parents or staff to the special baby care unit so that trained neonatal nurses and doctors could provide their care. This gap in service was due to a shortfall of neonatal staff.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Doctors reviewed high risk patients prior to discharge and midwives completed the physical observations and conversations with low-risk women. Two clerical discharge co-ordinators completed the documentation and made sure that the community midwives, health visitors and GP's were notified.

Midwifery Staffing

The service did not have enough midwives and support staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to make sure people were safe and gave locum staff a full induction.

Staffing levels matched the planned numbers most of the time. Staffing levels matched planned numbers most of the time and data reflected this. Maternity leaders reviewed staffing levels and reported outcomes to the board to ensure compliance to the Clinical Negligence Scheme for Trusts (CNST) and board papers confirmed this.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in March 2022 which was migrated to a new updated version in March 2023. This review recommended 257.45 whole-time equivalent (WTE) midwives Band 3 to 8 compared to the funded staffing of 255.40 WTE, a variance of just -2.05 WTE staff.

Managers told us they never needed to ask midwives to scrub for theatre cases due to not having enough theatre staff for emergencies, and that midwives were not upskilled for scrubbing. They said that recovery staff for obstetric emergencies were all main theatres recovery staff trained in recovery.

The service had high vacancy rates, which reflected the current national shortage of midwives. Twelve midwives had left the service in the 6 months before the inspection. The safe staffing update for April 2023 identified a midwifery workforce GAP of 16.99 whole time equivalent. The service had recently recruited 8 new midwives and had plans to continue recruiting and was sourcing overseas staff.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. Managers completed rosters 2 months in advance and any workforce gaps were backfilled using temporary staff familiar to the service.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that

something may be wrong with midwifery staffing. From December 2022 to the end of May 2023 there were 79 reported red flag incidents which showed 33 occasions of delayed or cancelled time critical activity, 17 occasions when staff were unable to take breaks and 14 occasions where there was more than a 2 hour delay in starting the induction of labour process.

Managers confirmed that in the event of delays to care and treatment medical staff reviewed each individual case to make sure that the most urgent cases were prioritised. Managers on the ward advised us that they were completing a quality improvement project to streamline the induction of labour process and staggered admissions based on risk.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. The service monitored compliance to the supernumerary status of the labour ward shift co-ordinator. The NICE 'red flag' data showed that there were only 3 brief occasions of 1 hour from December 2022 to May 2023 when this was not achieved for a whole shift.

The ward manager had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas. During inspection there was 1 midwife covering 2 patients on the enhanced maternity care unit. Staff told us the coordinator would arrange for an extra midwife if enhanced care women and birthing people needed 1 to 1 care.

The number of healthcare assistants did not always match the planned numbers. Midwives told us there was a lack of maternity support workers. The service had a housekeeper 1.0 WTE Monday to Friday and 3 maternity support workers, Band 2, working per shift on the delivery suite and birth centre. Included in their roles was to ensure restocking of rooms, making beds, and preparing labouring rooms for the next patient.

At night time the available support workers were often used to backfill housekeeping duties when the service did not have allocated housekeepers to support clinical staff. This meant that they were not able to help with supporting women or midwives with the clinical for example, maternal observations or to take blood samples.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

All new staff received 3 days corporate induction within 2 weeks of commencing employment within the trust. Newly appointed experienced midwives were given supernumerary status up to 4 weeks on commencement of employment.

Newly qualified midwives were offered a preceptorship programme at the commencement of employment after qualifying. The programme was provided over a 12-month period and newly qualified midwives were offered additional support by team leaders and practice development midwives.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The team included 4 practice development midwives and one professional midwifery advocate. Appraisal rates for midwives were over the trust target of 85% for band 5 and 6 midwives data up to June 2023 showed an average of 92%. However, appraisals for specialist midwives and managers fell short of trust targets at 83%.

Managers made sure staff received any specialist training for their role. For example, there were 43 specialist midwives who covered all aspects of midwifery care, these included but not limited to, a safeguarding midwife, an equity and

inclusion midwife, audit midwife, fetal wellbeing lead, perinatal health lead, substance and alcohol misuse midwife, antenatal screening midwife, bereavement, and infant feeding midwife. All specialist midwives were given additional training to carry out their roles and supported staff via training, clinical updates, and engagement, some of the specialist midwives received training in advanced midwifery practice and the professional midwifery advocate course.

Also, staff told us that staff working on the enhanced maternity care unit (EMCU) were allocated a band 7 supervisor and completed a 6 month course before being able to work on the EMCU, which included a 2 week placement in intensive care and an examination to pass at the end of the course.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number most of the time. The service had low vacancy, turnover and sickness rates for medical staff. The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly most of the time.

However, records indicated that there was not always enough medical cover during the late afternoon and evening and staff told us they waited longer for medical reviews in the afternoons. The audit data for waiting times in the Emergency Obstetric Unit (EOU) and records on the National Reporting and Learning System (NRLS) showed this had been reported by staff. This meant that although there were doctors allocated to cover triage (EOU), and although there was cross cover available from other doctors, medical staff were not always able to review women and pregnant people in a timely way due to also covering other areas.

The trust informed us there was consultant cover for EOU from 8am until 10pm, 7 days a week and off-site cover from 10pm to 8am, 7 days a week. There was also a second on call consultant available and on-site Monday to Friday from 8am until 4pm. The trust were assured of their escalation procedures.

There were 3 consultant obstetricians during the day. There was a labour ward consultant, a consultant for the elective caesarean section list (morning list of 3 cases every day during the week and an afternoon list on Tuesdays), and a consultant for the antenatal and postnatal wards, triage, and gynaecology. The consultant covering gynaecology covered gynaecology emergencies until 4pm, after which time the labour ward consultant covered these. This meant there was separation of labour ward emergency work for the labour ward consultant from elective cases and the other areas of the service, allowing them to focus on labour ward, until after 4 p.m. when they covered both obstetrics and gynaecology. One consultant provided inpatient and emergency gynaecology cover, and 1 consultant providing trust assigned Supporting Professional Activities cover making cross cover possible and ensuring the department always had senior cover.

The trust informed us, junior doctor cover overnight had been reviewed since inspection. There were now 2 SHOs at night, 1 covering obstetrics and 1 covering gynaecology. The SHO held both bleeps and went to where they were needed, for example, assisting in theatre, obstetric ward rounds, seeing unwell patients in the wards, helping out in EOU.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums were well supported and received a comprehensive induction.

The delivery suite was covered 98 hours a week with a resident doctor 8am to 10pm on site facilitating the Ockenden report recommended twice daily ward rounds. After 10pm, consultant cover was off site, with a requirement to return within 30 minutes.

There was a daily second on call consultant cover for inpatients who completed ward rounds and emergency gynaecology cover from 8am to 4pm on site on weekdays. After 4pm and at weekends 1 consultant covered the service off site, and was supported by 2 registrars, 2 SHOs and 1 SHO doing a half day on postnatal ward. There was a requirement that consultants should be able to return to the unit within 30 minutes.

The service had 2 consultant anaesthetists covering labour ward during the day, 1 on labour ward and another back up for labour ward who was not on the emergency team (resuscitation team). There was a separate consultant anaesthetist covering the elective section list. This meant emergency and elective work were fully separated in terms of anaesthetic cover. There was 1 consultant overnight covering both obstetrics and general theatres. There were 2 anaesthetic registrars for labour ward during the day and 1 for the elective section list, and 2 registrars overnight. The anaesthetic service was accredited with Anaesthesia Clinical Services Accreditation (ACSA), which is the Royal College of Anaesthetists (RCOA) accreditation scheme.

There was a maternal medicine consultant obstetrician with a maternal medicine team that liaised with other medical specialties. They risk assessed patients during the antenatal period and completed additional reviews on delivery suite. There were local weekly and regional monthly maternal medicine meetings and a database of patients under maternal medicine, including when they delivered. There was also an obstetric physician, who came to the service monthly, as part of the Northeast London Maternity Network link.

Consultants told us they worried about the retention of junior medical staff; this is because their most junior doctors had part time contracts. This meant, they were relying more on international medical graduates and were losing the tier of very senior registrars with advanced obstetric knowledge and skills.

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

Junior doctors told us they were well supported, there was always someone senior they could ask for help and they had opportunities to develop. They said they did not have any difficulties attending the weekly deanery teaching, including if on call.

Managers supported medical staff to develop through yearly, constructive appraisals of their work. Records showed that 96% of medical staff had received their appraisal.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, the combination of paper and digital care records posed a risk which was mitigated through continuous audit.

Maternity

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 8 paper records and found records were clear and complete. Managers completed a 6-month audit for December 2022 to May 2023 and looked at 10 sets of records per month. The audit was thorough and included all aspects of maternity care from the antenatal period to the postnatal period. The audit found that midwives completed risk assessments at the first booking appointment and recorded screening results correctly in 100% of records. However, the data showed that 20% of staff did not complete all maternal observations at every visit. Gaps in recording resulted in managers implementing an action plan which included recommendations for monthly audits to improve compliance.

The service was in the process of converting all paper records to a digital patient record platform which had to be designed specifically for Homerton University Hospital. The electronic system should have been implemented in May 2023. However, this had been delayed due to the need to update some of the risk assessments on the new record, leaders told us the implementation was planned for September 2023.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Staff gave women handheld written notes at booking and contained basic details and the results of blood and ultrasound scans so that if women did visit other areas they had basic information to give other healthcare providers.

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

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, there was an issue with the safe storage of medicines on labour ward.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. The system also had ‘power plans’ which were bundles containing prescriptions and associated blood requests and links to related guidance to help make it easier and quicker to complete all steps needed for various scenarios. We reviewed 8 digital prescription charts and found staff had correctly completed them.

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

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

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

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 10 sets of records we looked at were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. Staff received medication management training and understood their role in reducing the amount of medication errors. Staff report medication incidents via the trust incident reporting system. Leaders monitored errors for themes and trends to help inform training and development.

However, during the inspection we found that the door to the medicines storage room on delivery suite was continuously open. We raised this with trust leaders and immediately after the inspection they provided assurance that a new key code lock was fitted the following week.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff described what incidents were reportable and how to use the electronic reporting system. The coordinator told us all red flags should be reported on the electronic incident reporting system but was unsure whether this happened all the time.

Staff reported serious incidents clearly and in line with trust policy. We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly. Medical staff told us they felt the incident investigation process was fair and robust, open, and transparent. However, they said there were difficulties with having enough time to give to incident investigations and after action reviews.

The service had no ‘never’ events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers made sure that incidents were reviewed and investigated within safe time frames. Data showed that in May 2023 there were only 3 outstanding incidents and in June 46 incidents had been assigned and were under investigation.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations. Records showed that from December 2022 to May 2023 managers referred 6 poor outcomes to the Health Service Investigation Branch (HSIB) and 2 of the cases did not meet the HSIB criteria. We reviewed 4 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 4 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities. The service worked closely with a neighbouring hospital to complete fresh eye external reviews to make sure reviews were accurate and fair.

Managers shared learning with their staff about never events that happened elsewhere. The service had a ‘learning from incidents’ midwife who was responsible for sharing learning from incidents with staff. For example, medical staff held a CTG forum every week which started 3 months before the CQC inspection. Staff attended this if they were free, and it was also possible to join online as well. Staff also said they received CTG emails with case reviews and learning.

Staff told us there was protected time for the weekly departmental meeting for the multidisciplinary team where cases were presented. There was also a weekly perinatal morbidity and mortality meeting which staff told us was well attended and interactive.

Maternity

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at an obstetric clinical governance meeting in March 2023 and leaders reminded staff of the importance of declaring the urgency of an emergency instrumental delivery.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Medical staff told us they received emails from management about how incidents have been dealt with and the learning points from these. Staff were able to give examples of incidents they were involved in and confirmed that feedback and shared learning was passed on to them.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

Managers debriefed and supported staff after any serious incident. Medical staff told us they had felt well supported when a serious incident occurred. There had been a 'hot' debrief immediately and a further debrief afterwards. Those involved told us they had received personal feedback from the 72 hour review quickly. Medical staff told us the obstetric risk and governance lead consultant was very supportive and fostered a 'no blame' culture.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Trust leaders had the skills and abilities to oversee the service. They supported maternity leaders to develop strategies and policies for the local population. Maternity leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for women and birthing people and staff.

Homerton Healthcare NHS Foundation Trust board had oversight of the challenges faced by the surgery, women's and neonatal services division which included maternity services. Trust board papers confirmed that maternity services provided an update at the monthly meetings which conformed to the most recent Ockenden recommendations to ensure maternity services were included in trust-wide decision making and strategic change.

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

Maternity

The chief nurse, the divisional operations director, the director of midwifery (DOM) made up the divisional triumvirate. The DOM was also the lead for neonatal nursing and supported the senior nurse for neonatal services. However, the DOM was due to leave the service during the inspection period, but a replacement had been recruited and was due to start in September 2023.

The deputy director of midwifery (DDOM) supported the DOM and would 'act up' until the new DOM was in post. The DDOM helped manage 15 heads of departments across the division to deliver services to meet the needs of the local population and measure outcomes and performance.

The service was supported by 3 maternity and neonatal safety champions and a non-executive directors. The safety champions met bi-monthly and completed walk abouts of each area of the division and there was 'specific' monthly reporting to the board on maternity agenda items. The remit was influenced by the national priorities.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were respected, approachable, and supportive. Staff told us they were supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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

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

Homerton Healthcare NHS Trust announced and launched a new 5 Year Strategy, 'Our Future Together' which included input from the local integrated care systems North East London joint forward plan. The strategy had six key priorities, each with clear outcomes for success. The local maternity strategy was included within the following six strategic priorities which are:

1. Improve the health and wellbeing of our communities

2. Deliver outstanding, equitable care

3. Develop happy, healthy, and heard staff

4. Strengthen partnerships

5. Secure our future

Maternity

6. Foster innovation, improvement, and learning

The trusts key performance indicators and performance reports were aligned to their strategic priorities and were described as a 'golden thread' throughout the organisation from individual members of staff, each division up to board level.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and the planned to revision of the trust wide vision and strategy which included these recommendations. Board papers confirmed the key features and milestones of the maternity aspect of the strategy were:

- Delivering key maternity safety actions
- Achieving the Ockenden Essential Actions in collaboration with the Neonatal Operational Delivery Network
- Supporting the recommendations of the Neonatal Critical Care Review
- Facilitating and supporting leadership cultural development
- Supporting the recruitment, retention, and well-being of maternity workforce
- Supporting the training and education of maternity staff, in partnership with Health Education England.

The vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy. The 'Maternity and Neonatal Safety Champions Oversight Committee' April 2023 minutes confirmed that there was a new 3 year Maternity and Neonatal delivery plan which was designed to bring together the recommendations of several national maternity reports so that evidence is gathered in one place including safety actions for the 'Maternity Incentive Scheme'. The 3-year delivery plan had four key actions which were, listening and interacting with service users, review of workforce, culture and around safety and ensuring that cares are personalised.

Culture

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

Staff felt respected, supported, and valued most of the time**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff we spoke to felt supported and inclusive and staff on the postnatal ward told us they felt like a 'family' and supported each other.

The 2022 staff survey 45% of staff in the surgery, women's and neonatal services division which included maternity responded to the survey. The survey data did not separate feedback from specific areas like maternity therefore the data may not relate to all areas of maternity. In the survey only 59% of respondents felt safe to speak up about anything that concerned them, 69% of staff with known disabilities felt the organisation made reasonable adjustments to help them carry out their work and 66% felt they were given opportunities to improve their knowledge and skills. However, only 33% felt that appraisals helped them improve how they carried out their role and 46% reported harassment, bullying and abuse, from either patients and service users or colleagues.

Medical staff told us they felt well supported, leaders were approachable and they had opportunities to develop.

Maternity

Medical staff told us they felt the working relationship between midwives and doctors was very good, they felt part of a team and it was a friendly place to work. The culture had improved due to extensive work from trust leaders to eradicate poor attitudes and behaviours. The service now had external support for the lead consultant group session around handovers to make them less intimidating. Positive change had started to become embedded and junior doctors told us they did not feel bullied or undermined. One of the obstetric registrars had initiated mentoring system to support juniors so they can raise concerns if a professional systematic way.

Service leaders developed strategies to ensure that employees from minority ethnic backgrounds were supported in line with the NHS Workforce Race Equality Standard (WRES). There were plans to implement new information into next year's equality and diversity training, and there was a programme of reverse mentoring to support equal opportunities throughout the trust.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service employed an equity midwife to ensure equity for staff and patients. Managers monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. The board safety champions met with the freedom to speak up guardian to triangulate any cultural themes and devise solutions. For example, the funding of 2 MVP members from black and mixed black backgrounds to increase engagement with women of colour so that services would be reviewed to ensure they meet the needs of this group of service users.

Education leads developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff explained the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

Ward managers supported staffs cultural and religious norms' when workforce commitments allowed. Managers and staff told us that they adjusted shifts to make sure Jewish staff did not work during Sabbath and Muslim staff who requested nights during Ramadan were accommodated; also, during the Christian religious festival of Christmas the trust provided free meals to all staff.

Ward managers supported clinical staff in their career development. For example, they provided training sessions on how to audit aspects of care and how to investigate incidents, so that band 6 midwives who wanted to apply for band 7 roles had insight before they applied for more senior roles. However, band 2 support workers told us they felt frustrated because there were times when their work load did not reflect their job description. For example, they were regularly used for housekeeping and to provide meals to patients instead of support midwives with clinical care.

Maternity

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. Data from the trust from March to June 2023 showed that there were 9 formal complaints. The data showed the date of the complaint and the date when responses were due and action and responses taken. Complaints went through a quality control process to ensure accurate information was given to service users.

During the inspection process the CQC asked trusts to display a posted entitled 'Tell us about your experience of care'. After the inspection we received 94 responses and out of these there were 15 responses that were positive about care, 79 were complaints about the service. We noted that 56 of the feedback cited a combination of good care in the antenatal and labour period but all 56 cited poor postnatal care, with many women and people concerned about staff attitudes and lack of support and compassion on the post-natal ward. There were 15 complaints about poor care during labour which included communication and pain management issues. Finally, the remainder of complaints focused on the staff in the fetal medicine and emergency obstetric unit. During the inspection ward managers told us that they had increased staffing on the ward so that staff could have more time with patients based on feedback they had received via complaints.

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.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers.

The governance structure included a maternity clinical risk manager who was supported by an audit and guideline lead and a clinical governance lead the team had a maternity governance administrator to support them. The deputy director of midwifery and a consultant obstetrician oversaw the team. The team were responsible for governance throughout maternity and responsibilities included but were not limited to, making sure incidents were reviewed and categorised, the correct referrals were submitted to the Health and Safety Investigation Branch (HSIB), and that audits, investigations and key themes were identified to inform training and feedback to the local integrated care board (ICB) via monthly ICB meetings.

The team attend the monthly maternity risk meeting to look at common trends, held weekly multi-professional meetings with medical staff, anaesthetists and midwives and provided reports for maternity leaders to feed into the maternity dashboard exceptions report. The governance team worked closely with education to inform the following years training needs analysis.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. A 'Maternity Risk Management Review Committee' promoted the delivery of clinical excellence in maternity services and provided assurance to the board that standards of quality and safety set by local and national stakeholders were met. The committee was multidisciplinary and core membership included but was not limited to, an obstetric

clinical and risk leads, the director of midwifery and neonatal nursing lead, the deputy director of midwifery, the midwifery matrons, patient safety representatives, clinical practice educators, the quality improvement lead, the clinical risk manager, patient safety midwife and consultant midwives. The team had developed a clear terms of reference and were supported by a clinical governance administrator.

The group monitored standards and clinical quality through audit, to improve patient outcomes. The group oversaw the assessment and implementation of recommendations made in national guidance, external reports, audits, and inspections. The group met 10 times a year to review systems and safety and shared examples of good practice across maternity and neonatal care services and produced an annual risk management report on clinical governance and plans.

The committees were monitored at the 'Maternity and Neonatal Oversight Group' and the board of directors quality committee.

The Director of Midwifery had oversight of the maternity dashboard which was reviewed at the maternity review and management of risk meeting and fed into the maternity quality group which included maternity leaders, commissioners, and GP's. The dashboard was shared with the local maternity and neonatal system (LMNS) so that the information was used to capture a picture of services within the North East London Care Alliance.

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

The governance team held 'candour and cake' session for staff, the idea was that consultants and lead midwives talked about recent recommendations to support staff with understand duty of candour which requires all staff to be open and honest with patients and people in their care and to promote a health incident reporting culture.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Policies were available on the intranet; those due for review highlighted in amber and when they were out of date were highlighted in red to alert staff that there may be changes to national standards. We reviewed 10 policies which were in date or under review.

The divisional safety champions attended meetings like the 'Maternity and Neonatal Oversight and the 'Quality Committees', they had developed a terms of reference and had a standing agenda which look at the 3 year delivery plan for maternity and neonatal services. The safety champions reviewed the maternity dashboard exceptions and actions and the network quality dashboard. The safety champions fed back information from their walkabouts throughout the service where they spoke to service users and staff, also provided feedback to the board in a triple AAA format (Alert, advise and assure). Safety champions devised a newsletter so that staff were aware of progress. Records showed that in April the meeting focused on the end to end digital solutions, transitional care, and the Avoiding Term Admissions into Neonatal Unit (ATAIN) strategy.

Management of risk, issues, and performance

Maternity

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

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. Records confirmed that the trust contributed to national audits that included the saving babies lives version 2, the national diabetes audit, and the Sands Bereavement audit.

Also, the trust completed national compliance reviews and submitted data to national data collection platforms like the Maternity Incentive Scheme which fed into the Clinical Negligence Scheme for Trusts (CNST) reviews. The Maternity Incentive Scheme rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is through an incentive element to trust contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 4 (results published May 2023), the trust had not met three (out of ten) safety actions. The following actions were not met:

- Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions in to Neonatal units Programme?
- Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
- Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Leaders had developed strategies to mitigate the risk associated with non-compliance to the 3 actions. For example, the delay in implementing a full transitional care service triggered an action plan and we were told that lack of neonatal nurses and band 4 maternity support workers meant plans to open a transitional care bay were delayed but were included in divisional action plans, although the progress for implementing the service was slow which meant that new mothers had to visit the neonatal unit every 24 hours if their babies needed antibiotics or if they were unable to move they were separated from their babies whilst the babies were given care and treatment on the neonatal unit.

The service was unable to demonstrate compliance with all aspects of the Saving Babies' Lives care bundle Version 2 because of lack of compliance with recording of carbon monoxide (CO) monitoring during the later stages of pregnancy and there were times when the trust had not been able to re-order single use stock for the CO machines. Leaders were working with staff, the digital patient care record team, and the maternity voices partnership to improve the compliance to this aspect of saving babies lives.

Another safety action was that not all medical staff had multi-professional simulated obstetric emergency training. The service explained that junior doctors frequently rotate and they did not have reminders set on their staff records which meant there were times when all doctors were not aware their training had expired. Therefore, consultants were at the time of inspection delivering this training twice a month to improve compliance.

Leaders used the Perinatal Mortality Review Tool (PMRT) which is a national, standardised analytical framework used by healthcare professionals to question the entire course of care given to women and babies in cases of:

- **fetal loss** 22 to 23+6 weeks of pregnancy
- **stillbirth** both antepartum (before labour) and intrapartum (during labour)

- **neonatal death** (NND) from birth at 22 weeks of pregnancy to 28 days after birth
- **post-neonatal death** where the baby is born alive from 22 weeks of pregnancy but passes away later than day 28 of life if they received care in a neonatal unit.

Participation in PMRT is mandatory within the Clinical Negligence Scheme for Trusts (CNST), which offers a financial incentive for fulfilling 10 safety actions (NHS Resolution 2022). PMRT comes under safety action 1 if Maternity Incentive Scheme (MIS) standards. Due to the pressures created by COVID-19, CNST deadlines remained paused at the start of this quarter, relaunching again on 6th May 2022. Maternity and neonatal leaders produced detailed reports for the trust board which included outcomes and information on the participation of parents during the review process.

Consultants held weekly perinatal/maternity meeting with the neonatal team and a weekly chart review and maternity risk meeting for obstetricians and midwives, which well attended by the consultants. Also, they had a bimonthly joint anaesthesia, midwifery, and obstetrics meeting and there was a monthly fetal medicine/neonatal meeting.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. The service completed an annual maternity audit programme and records showed that the service planned 45 locals and 4 national audits from April 2022 to March 2023.

Managers shared and made sure staff understood information from the audits. Throughout the maternity unit outcomes of audits were displayed and discussed at handover. Records showed that audit outcomes were presented in a way that staff could understand.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

The top 3 risks for maternity were recorded on the internal risk register which fed into the corporate risk register. The lack of digital cohesive digital care records, pathology (delays in investigating blood tests) and the lack of clinical space for the safeguarding midwife. Divisional leaders planned actions to mitigate the risks and to develop strategies for safer systems. For example, the plans to implement a more reliable maternity patient care record was in progress. The issues with pathology were created because of a national restructure of pathology services moved to a more centralised system with the main hub located at a neighbouring trust which created incidents around screening tests, improvements have been made, however, this risk remained on the risk register. Finally, to source a space so that the safeguarding team could safely review vulnerable women with complex social lives.

The requirement for elective caesarean sections had increased since the COVID-19 pandemic to around 40-45% in a month. Staff told us there were an increasing number of people requesting caesarean sections and meeting this demand was increasingly difficult due to the size of the unit. A business plan had been completed and more theatre sessions were needed to accommodate the numbers, but there were currently not enough consultants to deliver this. However, they had recently recruited another consultant. They recognised that capacity for elective sections needed to be increased so had placed elective sections on the risk register. They had mitigated the shortfall in capacity by doing Saturday lists to reduce the backlog of cases, but recognised this difficulty would require increasing consultant capacity and corresponding job planning.

Maternity

Staff told us antenatal clinics were overbooked and there were not enough rooms, with rooms having to be shared with midwives in clinic, and about half of the consultants did not do antenatal clinics.

There were plans to cope with unexpected events. The service had a detailed local business continuity plan. The emergency escalation policy was under review because the service wanted to align to national standards in terms of their capacity status which meant that all managers needed to understand the process and feedback any issues with the draft policy before it could be implemented.

Information Management

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

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

The dashboard was colour coded in red, amber, and green. Green indicated that the trust was on target, amber highlighted potential risk, and red highlighted required actions. For example, the April 2022 to March 2023 dashboard showed that in May, June, November 2022, and March 2023 the total number of bookings exceeded the planned number of bookings. This information was important because it influenced service and workforce development. Data showed that the service set a target of 15% for birth centre (low risk births) which they had not been able to achieve, the rates for the same period showed that deliveries on the birth centre ranged between 10.4 to 14.56%. This information was fed into the local maternity and neonatal systems and the local integrated care board to help tailor care to the needs of the local population.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The trust provided its own intranet which had links necessary information and standard operating procedures for all divisions within the trust.

The information systems were integrated and secure**.** The trust provided staff with unique pass cards and security codes to access patient records and use of patient records could be audited.

Data or notifications were consistently submitted to external organisations as required. Records and audit data provided by the trust to the CQC and other organisations was accurate, organised and easy to understand and demonstrated that there were safe information management systems within the service.

Engagement

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

Maternity

North East London Integrated Care System (NEL ICS) forward plan strategy was shared with the trust board. The NEL Integrated Care Board developed an associated, nationally directed, 'Joint Forward Plan.' The draft plan was co-produced and shared at several groups and forums, including the City & Hackney Partnership and the Acute Provider Collaborative Executive, where Homerton Healthcare executives had the chance to comment. This plan was submitted to NHS England at the end of June 2023.

Homerton University Hospital was located closely to other hospitals in East and West London that provided maternity care. Because of it had established links and a positive reputation within the community records confirmed that 50% of mothers who delivered their babies at Homerton University Hospital had booked their care at other units. Service leaders recorded this as a risk met local integrated care boards and the local maternity neonatal systems every month with the safety champions to devise strategies to make sure they had full oversight of women and birthing people who migrated from one hospital to another.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP comprised of 3 members, 2 represented the Black and Black mixed origan communities which was 13% of Homerton University Hospital and one member to represent other communities and an MVP champion who represented the large Orthodox Jewish population. The MVP told us that Homerton University Hospital were responsive and currently the MVP attended the maternity board meetings. However, the MVP recognised that there was unequal equity with regards to gaining feedback from women and birthing people from Asian, and other groups, with protected characteristics, and mental health conditions and learning disabilities.

The service made available interpreting services for women and birthing people and birthing people and collected data on ethnicity. Leaders collected ethnicity data as part of their London Maternity and Neonatal Indicators which showed details of most ethnic groups but did not show the amount of people booked from the Roma and Gypsy communities or people with protected characteristics like learning disabilities as reflected in the Equality Act (2010).

Staff used telephone interpreting services in the hospital unless there was an identified risk which meant staff would request face to face interpreters. The service cared for a diverse population of women and birthing people where English was not their first language. Staff told us there was a dedicated midwife, MVP, and antenatal classes for these populations.

Although information leaflets were available in different languages, staff told us they were still encountering rarer languages and it was these rarer languages that presented more of a challenge.

Staff told us they used a wireless phone so by the bedside to allow women to speak via interpreters. If the required language were not available in then they would seek members of staff who could speak the language or use family members. Telephone interpreting services are not best practice for women using shared bays on the wards or in clinical because of the level of background noise. Also, for safeguarding reasons staff should not rely upon families to interpret to give women the opportunity to voice any safeguarding concerns alone. Staff told us that there was a trial of new 'interpreter on wheels' technology as part of a quality improvement programme.

Leaders understood the needs of the local population. Homerton Healthcare NHS trust covered an area of London that was diverse and extensively populated by the Jewish community. Leaders engaged actively with local Rabbis, and Jewish organisations . Leaders engaged with the Jewish doula association who provided support and care during labour. Relationships had been established over time to make sure that cultural and religious needs were met. For example, during Sabbath a group of Jewish volunteers stored kosher snacks in a key code cupboard on the postnatal ward for Jewish mothers and displayed the passcode in Hebrew.

Also, leaders made sure that women and families from the Muslim, Christian and other common faiths had their prayer and dietary needs met. Charity money was gifted to the service to that it could be used to fund a black and black mixed heritage group and plans to produce an anti-racism framework for maternity.

The team had developed relationships with the local ambulance service to provide obstetric emergency training for paramedics in the event of a baby being born before arrival to the hospital.

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.

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

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

The service appointed an equity lead who invited staff to become involved in a strategy that ensured equality opportunities to all staff including those with protected characteristics in line with the Equality Act (2010). A road map was set up and an inclusion group created with a focus on Homerton University Hospital setting a core value as an 'Anti-racist' organisation.

Outstanding practice

We found the following outstanding practice:

- The embedded relationships with the local Jewish community which accounts for just over 12% of women who have their care at Homerton University Hospital. Service leaders regularly engaged with the community, provided fetal wellbeing training to Jewish Doulas who support Jewish women during labour, provided a locked cupboard which was stocked by the Jewish community with Kosher snacks for new mothers and was accessed by a Hebrew key code. Also, by engaging with the local Hatzalah voluntary Jewish paramedic group, who transfer women to the hospital for care.
- On labour ward staff gave birth partners a wristband to identify them, this meant the ward clerk would not have to keep asking for their details each visit. Staff told us there would usually be a picture of partners known to be a risk to women and birthing people on labour ward at the ward clerk's desk to identify them, and that ward clerks would be briefed about these cases.

Areas for improvement

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

Maternity

Maternity

Action the trust MUST take to improve:

- The service must ensure sufficient medical staffing is planned for triage to make sure women and birthing people are reviewed within safe time frames. Regulation 12 (1)(2)(c) Safe Care and Treatment
- The service must ensure medical training compliance, such as obstetric emergency training meets trust targets to ensure the safety of women and birthing people and babies. Regulation 12 (1)(2)(c) Safe Care and Treatment

Action the trust SHOULD take to improve:

- The service should ensure that it implements the planned new maternity digital records as planned.
- The service should ensure that it improves the design and equipment within the bereavement room to reflect national recommendations and is sufficient to provide dignity and privacy to bereaved parents.
- The service should ensure that it continues to monitor and limit the amount of equipment stored in the theatre corridors.
- The service should ensure that the local continuous electronic fetal monitoring standard operating procedure for using 'fresh eyes' assurance reflects national guidance of one hour.
- The service should ensure it continues to improve compliance to recording carbon dioxide monitoring at 36 weeks of pregnancy.
- The service should ensure that it improves medical cover in triage and the emergency obstetric unit during the night and at weekends to reflect national recommendations.
- The service should ensure that it continues to develop and implement a clear telephone triage system so that women and people have 24 hours safe access to the service.
- Managers should ensure it improves staff compliance to accurately complete the SBAR handover tool.
- The service should ensure it continues to improve workforce levels within maternity services.
- The service should improve the quality of interpreting services within the maternity unit and staff should avoid asking family members to interpret.
- The service should ensure that it continues to monitor care provided by staff on the postnatal ward to make sure women and people are cared for in a safe positive environment.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector, two registered midwives and one obstetrician who conducted remote interviews. Carolyn Jenkinson our Deputy Director of Secondary and Specialist Care oversaw the inspection team.