Barts Health NHS Trust

Newham University Hospital

Quality Report

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

Ratings

Maternity and gynaecology	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Newham University Hospital, East London is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across East London.

The hospital provides maternity services to women in the London Borough of Newham and the Barking ward of the London Borough of Barking and Dagenham. The unit delivers around 6,500 babies every year, and numbers are increasing each year.

This was an unannounced inspection. Its purpose was to follow up on concerns about the maternity services identified at previous CQC inspections in November 2016. We did not conduct an in depth review of evidence against each of our five key questions and key lines of enquiry, hence we have reported our findings under two domains: safe and well-led.

Gynaecology services were not inspected on this visit.

Our key findings were as follows:

- Whilst there had been improvements and some progress against the previous requirement notice issued for governance and assurance in the maternity unit, there was still a need to improve and strengthen governance structure and reporting systems.
- Staffing issues continued to impact the delivery of care. Although there had been some staff recruitment, there continued to be shortages of midwifery staff at the time of our inspection. This included a shortfall in the number of experienced midwives. Whilst consultant cover had increased to 98 hours on the labour ward, out of hours cover was overstretched leading to delays in care.
- At the last inspection we had raised concerns about record keeping. The most recent cardiotocography (CTG) audit in February 2017 highlighted there were continuing problems with CTG record keeping, including incomplete documentation of risk factors, and failure to consistently comply with correct procedures for filing CTG documents. The trust had introduced measures to address the issues raised; however,it was unclear how CTG record keeping and oversight had improved as further auditing was yet to take place.
- At the previous inspection in November 2016, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. At this inspection the trust had implemented the electronic baby tagging system which had increased security. Further work was required to ensure all visitors to the maternity wards were monitored and signed in appropriately.
- Systems were not effective enough in monitoring the outcomes of audits and incident reports.
- Plans were in place to monitor and drive improvements throughout the maternity service, however progress was slow.
- Since the last inspection, some improvements had been made in assessing and monitoring the quality of the service with systems in place to improve engagement with staff.
- Most staff commented there had been improvement since the last inspection with the leadership much more visible and visiting the units on a regular basis.
- The trust had made progress in revising the governance team structure for women's services, and progress on improving governance leadership with a new obstetric lead for clinical governance appointed in May 2017.
- There was an effective training programme for midwifery staff, although some midwives emphasised the lack of time they had to engage with this.
- Trainee doctors continued to be well supported and had opportunities to put their learning into practice.
- Processes were in place to assess and manage risk. These included the use of team briefings and the World Health Organisation (WHO) surgical safety checklist in obstetric theatre
- The service had a plan for continuous improvement in the management of infection prevention and control, and we saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness

Summary of findings

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Take steps to ensure sufficient numbers of appropriately skilled staff are deployed to meet the needs of the service.
- Ensure that women receive timely treatment and pain relief, and that out of hours medical cover is effective in responding to and meeting the changing needs and circumstances of people using the service.
- Ensure all overdue serious incident reports are reviewed, actions are completed, learning is disseminated in a timely way, and processes are in place to effectively monitor progress.
- Ensure learning from incidents is used for the purposes of continually evaluating and improving services.
- Ensure that patient records, including cardiotocography (CTG) documentation, are comprehensively and consistently completed and that processes are in place to evaluate this

In addition the trust should:

- Ensure processes are properly utilised so that mothers and babies are kept continuously safe from unauthorised access to the units.
- Ensure delivery suite coordinators have supernumerary status with sufficient allocated time and resources to carry out their oversight and support role.
- Further consider funding for staffing a second obstetrics theatre to improve waiting times for caesarean.
- Take further action to ensure compliance with the trust's target of 90% completion of mandatory training, including safeguarding training.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Requires improvement 	

Newham University Hospital

Detailed findings

Services we looked at
Maternity and gynaecology

Detailed findings

Contents

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Maternity and gynaecology

Safe	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Newham University Hospital provides maternity services to women in the London Borough of Newham and the Barking and Dagenham wards of the London Borough of Barking and Dagenham. There were 5,969 births between January 2016 and December 2016.

The trust's maternity service at Newham University Hospital provides antenatal, intrapartum and postnatal care to patients. The service also includes a delivery theatre in the main theatre suite and provides community based midwifery services. Maternity is formed of many services – including 24 hour maternity assessment, induction of labour, inpatient antenatal care, triage and a maternity helpline. They are located together into one purpose-built section of the hospital, accommodating up to 6,500 births per year.

The hospital has a range of antenatal and postnatal services, including early pregnancy diagnostics, and inpatient and outpatient antenatal screening and assessment. All women attend the hospital for their first appointment. Community midwifery services deliver antenatal and postnatal care for all women in the catchment area. Specialist antenatal clinics are run for women with additional conditions such as diabetes, or mental health, heart, kidney or neurological problems.

The maternity unit has two delivery areas. The central delivery unit (a shared consultant/midwifery led unit) has 15 delivery rooms. There is a co-located birth centre with 9 birthing rooms. There is one obstetric theatre. The inpatient ward (Larch Ward) has 41 beds for antenatal and postnatal care, and induction of labour. Six of these were fee-paying amenity rooms where a partner can stay overnight. Women also have the choice of a home birth and a standalone birthing centre.

The day assessment unit is attended by women over 20 weeks pregnant who have complications of pregnancy. Women attending the maternity unit are triaged (have their care assessed) by a midwife and are directed to the most appropriate facility.

The obstetric unit is the recommended place of birth for women with complicated pregnancies or those who go into labour before 37 weeks. It is also available for women who would like a natural birth experience with medical expertise close by. There is a high dependency unit for mothers who develop complications around the time of birth and require close monitoring. A level 2 neonatal unit is on site for babies born prematurely or needing additional support after birth

Newham University Hospital has a designated labour ward, a standalone birthing centre, alongside a midwifery-led unit, and a home birth team. The antenatal and postnatal ward is combined and consists mainly of single rooms.

Community midwives are aligned to a GP practice and are employed by the maternity service to provide both antenatal and postnatal care for women and their babies and provide a home birth service.

In the alongside midwifery-led unit there are approximately 120 babies delivered a month. All 10 rooms at Newham birth centre have birth pools. In the standalone Barking Community Birthing Centre there are 20 babies born each month. There are four rooms of which two have fixed pools and two have inflatable pools.

Birth centres are suitable for women who have a normal, 'low-risk' pregnancy, go into labour between 37-42 weeks, and are expected to have an uncomplicated birth. Birth centres provide access to 'active birth' equipment including birth balls, mats, and birth stools. Individual rooms where partners can stay with en-suite facilities are provided where patients can prepare their own drinks, as well as prepare formula feeds when required.

Maternity and gynaecology

Maternity staffing includes: consultant obstetricians and obstetric team; consultant anaesthetists and anaesthetic team; consultant neonatologists and neonatal team. Midwives and midwifery assistants, operating department practitioners and theatre nurses; admin clerks and housekeepers

We visited all areas of the maternity unit and talked to midwives, support workers, obstetricians, senior managers, women attending the antenatal clinic and women who had recently given birth.

We previously inspected the service in November 2016, where we carried out an unannounced focused inspection and visited: the labour ward, all maternity wards, the antenatal clinics, the early pregnancy assessment unit, operating theatres and the maternity assessment unit.

The purpose of this unannounced inspection was to follow up concerns about the maternity services identified at inspection in November 2016.

We did not conduct an in depth review of evidence against each of our five key questions and key lines of enquiry, hence we have reported our findings under two domains: safe and well-led.

We did not inspect gynaecology services on this inspection.

We did not inspect termination of pregnancy services on this inspection.

We spoke with six women and 28 members of staff within the service. We observed care and treatment and looked at 10 care and medical records. We received comments from people who told us about their experiences and we reviewed performance information about the trust's maternity service.

Summary of findings

Overall we rated this service as requires improvement because:

- Whilst there had been improvements and some progress against the previous requirement notice issued for governance and assurance in the maternity unit, there was still a need to improve and strengthen governance structure and reporting systems.
- In November 2016, we had identified there was insufficient consultant cover. On this inspection we found there had been improvement with consultant cover increased to 98 hours. However, staff continued to raise concerns and told us there continued to be delays with women waiting longer for pain relief and treatment due to anaesthetists being busy elsewhere and not able to attend when requested. Out of hours consultant cover was overstretched leading to delays in care.
- Although there had been some staff recruitment, there continued to be shortages of midwifery staff at the time of our inspection, leaving midwives overstretched. Several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly and this could impact on women's care.
- At the last inspection we had raised concerns about record keeping. The most recent cardiotocography (CTG) audit in February 2017 highlighted there were continuing problems with CTG record keeping including incomplete documentation of risk factors, and failure to consistently comply with correct procedures for filing CTG documents.The trust had introduced measures to address the issues raised; however, it was unclear how CTG record keeping and oversight had improved as further auditing was yet to take place.
- Systems were not effective enough in monitoring the outcomes of audits and incident reports. At the last inspection serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem. The audit identified

Maternity and gynaecology

incomplete documentation as a theme. However, there were no clear action plans in place to regularly audit or monitor progress to improve the quality of documentation.

- We saw plans to monitor and drive improvements throughout the maternity service, however progress was slow and some of these plans had not yet been implemented.
- Since the last inspection, some improvements had been made in assessing and monitoring the quality of the service with systems in place to improve engagement with staff. We found a mixed response with several staff repeating the same concerns and stating morale was low and others stating it had improved. Difficulties remained in gaining the support of midwifery staff affected by changes the trust had imposed since the last inspection in 2016.
- At the previous inspection in November 2016, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. At this inspection the trust had implemented the electronic baby tagging system which had increased security. Further work was required to ensure all visitors to the maternity wards were monitored and signed in appropriately.

However, we also found:

- The trust had made progress in revising the governance team structure for women's services, and progress on improving governance leadership with a new obstetric lead for clinical governance appointed in May 2017. Most staff commented there had been improvement since the last inspection with the leadership much more visible and visiting the units on a regular basis.
- There was an effective training programme for midwifery staff, although some midwives again commented that they did not have time to develop their skills outside the framework of mandatory training because they were so busy. However, we found trainee doctors continued to be well supported and had opportunities to put their learning into practice.
- Processes were in place to assess and manage risk. These included the use of team briefings and the World Health Organisation (WHO) surgical safety checklist in obstetric theatre
- The service had a plan for continuous improvement in the management of infection prevention and control, and we saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe requires improvement because:

- At our previous inspection in November 2016 we identified there was insufficient consultant cover. On this inspection we found an improvement with consultant cover increased to 98 hours. However, staff continued to raise concerns and told us their continued to be delays with women waiting longer for pain relief and treatment due to anaesthetists being busy elsewhere and not able to attend when requested. Out of hours medical cover at all levels was overstretched, leading to delays in care.
- The trust had been working to recruit more staff and had increased its staffing levels, recruiting more newly qualified midwives. However, lack of experienced staffing was still an issue and staff told us mothers in labour did not always get one to one care in early labour. The maternity unit had a high proportion of complex cases and we observed midwives to be overstretched.
- Whilst there had been improvements and some progress against the previous requirement notice issued for governance and assurance in the maternity unit, there was still a need to improve and strengthen governance structure and reporting systems. There continued to be concerns about the categorising and length of time the trust took to complete incident reports and serious case reviews. There was a lack of evident assurance that learning was properly followed up and embedded.
- At the last inspection we had raised concerns about record keeping. The most recent CTG audit in February 2017 highlighted there were continuing problems with CTG record keeping, including incomplete documentation of risk factors, and failure to consistently comply with correct procedures for filing CTG documents.The trust had introduced measures to address the issues raised; however, it was unclear how CTG record keeping and oversight had improved as further auditing was yet to take place.
- A bid to fund a second theatre had been in place prior to put last inspection and this had not progressed. The hospital's emergency theatre team was relied upon to provide support to the maternity service. Midwives raised concerns about delays this caused with women waiting longer for operations because there was no second dedicated theatre.
- At the last inspection we had noted that mortality and morbidity meetings were held regularly, although no minutes had been kept of discussions. On this inspection, we saw staff were taking notes of these meetings; however, it was unclear what actions had been agreed and how these would be followed up as there was no clear agenda or system to review decisions.
- Overall, the trust were not meeting its target to ensure all midwifery, nursing, obstetrics and gynaecological staff had the required training in safeguarding. There were gaps in the number of staff that had completed their statutory and mandatory training and levels were below the trust's target.
- At the previous inspection in November 2016, the security of babies in maternity services had been identified as a risk because of insufficient staff to monitor access to the unit. At this inspection the trust had implemented the electronic baby tagging system which had increased security. Further work was required to ensure all visitors to the maternity wards were monitored and signed in appropriately.

However, we also found:

- Processes were in place to assess and manage risk, including systematic antenatal assessments of women at risk, the use of team briefings and surgical safety checklists in obstetric theatres.
- At our last inspection we had concerns as to the lack of use of modified early obstetric warning score (MEOWS). On this inspection, we found that this had been addressed.
- The service had a plan for continuous improvement in the management of infection prevention and control, and we saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness.
- Medicines were safely managed, accurately recorded, in-date and securely stored in locked rooms or locked fridges.

Incidents

Maternity and gynaecology

- At the last inspection in November 2016 we had significant concerns that systems and processes for incident reporting and investigation were not safe. Following previous inspections external stakeholders, including commissioning bodies and the trust reviewed the systems for reporting and investigating incidents.
- Between May 2016 and April 2017 Newham University Hospital reported 22 serious incidents (SIs) in Maternity and Gynaecology which met the reporting criteria set by NHS England. Of these, the most common type of incident reported was Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant).
- Between June 2016 and July 2017 there were 1710 incidents reported for the maternity and gynaecology service. At the last inspection there had been a backlog of more than 150 incidents waiting to be reviewed, which had led to a delay in learning. The trust had worked with commissioners to review overdue incidents and SI's with a plan for completion by December 2016. By the beginning of January 2017, overdue SI actions were reduced to 19 and the service had 31 incidents overdue for review. This remained a work in progress, and the July 2017 divisional performance report stated there were 24 SI actions overdue. Data within the same report shows overdue incident investigations as being at 29 in April rising to 63 in May, impacted by a trust wide IT outage.
- The trust reported five root cause analysis (RCA) reports outstanding from the last inspection in November 2016. There continued to be delays in meeting their target in their adverse incident policy which stated there was a maximum 60 working day deadline for reporting on and submitting to commissioners. This meant there continued to be a potential risk of the situation being repeated.
- At the last inspection we had found that not all incidents had been correctly identified as a SI. We had seen examples where similar outcomes had been categorised differently and the reason given by the trust did not follow their own guidance on categorisation as stated in the trust's adverse incident policy. On this inspection we reviewed incident reports and saw there continued to be examples of incidents that did not follow the trust policy on categorisation**.** There were concerns about the processes for managing incidents and continuing concerns about lack of assurance that learning was properly followed up and embedded. However, there had been some progress with weekly quality and safety meetings in the process of being started with the site executive team to ensure incidents were appropriately categorised.
- At the last inspection we saw that mortality and morbidity meetings were held regularly and doctors gave presentations on specific cases. However, it had not been clear how learning was drawn from these meetings to influence future practice, because no minutes or actions were recorded. On this inspection we saw minutes of two Perinatal Mortality meetings. In one meeting six cases had been reviewed with three graded as the patients having received "suboptimal care" - where different management might have made a difference to the outcome. However, there were no evidence these had been followed up as there were no action plans in place and no evidence of how outcomes were monitored to ensure learning was embedded in staff practice. The trust told us they regularly circulated a "risk management newsletter". However, we were not assured effective processes were in place to ensure staff followed the recommendations.
- The trust told us staff were provided with information about incidents through newsletters and memos from the governance team. We found staff understood how to raise concerns and record safety incidents including concerns and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw evidence where these were shared with the relevant managers. However, as found on the last inspection, systems for ensuring individual feedback shared with staff were very much dependent on individual managers. Some staff continued to report they did not always get to hear the outcome of incidents they had been directly involved in and feedback on others was variable.
- Staff were aware of actions they should take when a 'reportable patient safety incident' occurred and assured us they were open and transparent. They were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant

persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Managers accurately explained what responsibilities they had under the duty of candour.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing harm free care. The hospital used its own variant of this and performance information the trust collected was displayed on wards along with other performance indicators. This meant safety performance information was available to patients and their families.
- The maternity department had systems in place for recording and monitoring performance. This included reporting the number of hospital acquired infections, the number of medication administration errors, friends and family test response rates, and maternity staffing levels.
- Maternity information collected included, the percentage of inductions of labour, number of caesarean section deliveries, complications of labour and delivery, number of stillbirths and breech births. And the number of women receiving one to one care in labour.
- On this inspection there had been improvement with consultant cover on the labour ward reaching its expected 98 hours from September 2016 onwards.
- Between September 2016 and April 2017, the 98 hours of obstetrics and gynaecology consultant cover included both obstetrics and gynaecology duties. The trust provided evidence to show that in May 2017 separate obstetrics and gynaecology consultant rotas had been introduced. This had enabled the labour ward obstetric consultants to be fully dedicated to labour ward cover.
- At the weekend an obstetrics consultant was available from 8am to 4.30pm. After this time there was on-call cover from 4.30pm to 8am, which may be on or off-site, so the consultant may not be immediately available. We were told that not all consultants participated in the on call rota.
- On weekdays there was labour ward cover between 8am and 5pm on site. The night on-call consultant was available until 10pm. The hospital had introduced a resident on-call consultant in September 2016 for two nights a week in line with the Royal College of Obstetricians and Gynaecologists' recommendations in their workforce report of November 2016. This meant that from 1pm to 4pm and 9pm to 8am on a Monday and a Thursday there would be 24-hour consultant on-call presence available. On-call consultants would take calls from home and had a low threshold to come in and assist if needed. The Trust was continuing to work towards a more balanced rota pattern as it progressed its business case for a second obstetric theatre.
- At the last inspection we reported that between April and September 2016 (six months) there had been 107 unexpected admissions to the neonatal unit and 310 transitional care admissions. During the same period, 19% of women had an emergency caesarean section. This had been higher than the England average of 15%.
- On this inspection the trust provided information for April to June 2017 (three months). There were 57 unexpected admissions to the neonatal unit (NNU) and 168 transitional care admissions.
- During the same period 20% of women had an emergency caesarean. 25% of women had their labour induced, which was better than the England average of 27%.
- The total percentage of patients that required a caesarean section was 26.8% which was higher than the national average of 25%. The hospital had a high percentage of women with complex needs and was aware it had a higher than average number of caesarean section, with an action plan in place to review its processes.
- At the last inspection we reported that over the twelve month period April 2015 to March 2016 there had been 31 stillbirths and in the six months from April to October 2016 the stillbirth rate had increased to 24 stillbirths. At that time we had not seen any meeting discussions or action plan that acknowledged the trust were aware of, and were looking at, the reasons for the increase in stillbirths.
- On this inspection we found there had been six stillbirths in the three months between April and June 2017. The trust told us that since the last inspection they had planned an audit to look at stillbirth rates which was due to report in November 2017; however, at the time of our inspection, this had not yet begun.
- At the last inspection safety thermometer information on post-partum haemorrhage rates had been available for the six month period April to September 2016. This

showed the overall percentage of post-partum haemorrhage was 2.6%. On this inspection information showed that April and June 2017 rates were similar at 3%.

- The number of women assessed by midwives and obstetricians for risk of venous thromboembolism (VTE) was 98.6%; the service had reminders in safety updates for staff to assess all women for VTE risk, which was being audited internally. Senior managers were monitoring audit outcomes to improve compliance and achieve a 100% compliance rate.
- The performance score care reported there were two "unit divert/closure episodes" between April and June 2017. Incident reports we viewed confirmed these were because of pressures on the service due to lack of beds and staffing levels.

Cleanliness, infection control and hygiene

- The trust had policies for screening and treatment of c.difficile and MRSA infections. Over the last year there were no reported infections of either MRSA or C.difficile within the service.
- Medical and midwifery staff had access to training in sepsis management, infection control and prescribing antibiotics during their induction.
- All staff were required to complete infection control level one and two mandatory training. The majority of staff were recorded as completing this training. Level three infection control was mandatory for midwifery staff. The trust completion target of 90% was not being met. Records showed completion rates of 63% for the ante-natal unit, 67% in the neonatal unit, 71 % in midwifery and 81% in medical obstetrics and gynaecology.
- The service had an annual infection prevention and control team programme of work for 2017/18. This showed the service had a plan for continuous improvement in the management of infection prevention and control. Monthly audits were undertaken with staff compliance meeting the trust target of over 90%.
- Hand sanitising gel was available within the clinical areas, and we saw reminders, prominently positioned to remind staff and visitors to use it.
- Staff followed hospital policy and 'bare below the elbows' guidance. Personal protective equipment, such as gloves and hand-washing facilities were available. We observed staff using personal protective equipment appropriately, which was in line with national guidance.
- We saw evidence that cleaning staff adhered to standards, practices and the required frequency of cleaning. The intrapartum areas were appropriately designated a high risk area and audited weekly. We saw good results from infection control audits. Women told us they were satisfied with the standard of cleanliness. We saw 'I am clean' stickers in all the areas we visited, with the day's date to indicate a clinical item was ready to be used again. Areas we visited were clean and tidy.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in each consulting room. These were dated and were not overfilled.

Environment and equipment

- At the previous two inspections, security had been identified as a risk because of insufficient staff to monitor access out of the unit. Visitors were admitted without checking their names or who they were visiting, which was a potential risk to women and babies. The trust told us a visitor log was kept by the person at the reception desk.
- We looked at the overnight visitor log book on Larch ward and saw it was not regularly completed. The last entry was dated November 2016. Partners staying on maternity wards overnight were requested to sign in to the ward so a record could be kept; however, ward minutes recorded that not all partners were signing in. Staff had been requested to be more diligent and ensure records were up to date.
- During this inspection we found improvements had been made to baby security. All the areas where babies were cared for were secure, with locked doors and intercom communication that could only be opened by internal mechanism or by a swipe card system on the outside.
- Some doors could be opened on the inside by anyone wanting to leave the area and the area was not always monitored. The trust told us additional bank receptionist cover had been provided to mitigate this.
- The introduction of the electronic baby tagging system in February 2017 had reduced risks and improved baby

security. Several staff told us there were some problems with tags being put on too loose and coming off. Regular checks were in place to ensure babies tags were in place and staff would be alerted if babies were removed from the ward.

- Everyone we spoke with was clear what they should do should this happen. An allocated HCA checked all baby identification labels daily and flyers for parents were by each bed side informing them that babies must have two name bands as well as an electronic tag.
- There was only one staffed obstetric theatre. At the last inspection many staff had commented on the difficulties this caused for women such as having to wait longer for a caesarean. On this inspection staff continued to voice concerns and a bid previously put forward for funding for staffing a second theatre had not progressed.
- Resuscitation equipment was available for use in an emergency. Staff were allocated to check resuscitation equipment and we saw that checks were recorded. The trolley drawers were not tagged, so were accessible to unauthorised persons. We were told it was not the hospital policy to tag resuscitation trolleys, which could be a risk in an area where small children could tamper with them. Staff said they felt that although they knew it was a risk they would rather trolleys and equipment were easily accessible.
- Cardiotocography (CTG) equipment was available and equipment had been safety tested. CTG is a test usually done in the third trimester of pregnancy. It is done to see if baby's heart beats at a normal rate during contractions.
- Foetal blood analyser and foetal heart rate monitoring equipment for high risk pregnancy monitoring was available and safety checked. Laboratory facilities and blood products were available if required.
- An electrical maintenance team were responsible for annual safety testing. The equipment we looked at all had an up to date safety test and appeared in good condition.
- Waste management was compliant with national guidance. Arrangements were in place for safe disposal of waste and clinical specimens.

Medicines

- A named pharmacist visited the maternity unit daily. Stock arrived weekly and was topped up by a pharmacy technician when required.
- Medicines were safely managed, accurately recorded, in-date and securely stored in locked rooms or locked fridges. Fridge temperatures were monitored daily. We checked the controlled drugs register and saw that daily stock checks were recorded and stock levels were correct.

Records

- Women kept their own pregnancy-related care notes in handheld records (the green notes), taking them with them when they attended the maternity unit and for examinations with their community midwives. Care records we viewed contained information about pain relief. Women's options included epidural analgesia, opiates, nitrous oxide (gas and air), use of a birth pool and paracetamol.
- At the previous inspection we found that record keeping was not always meeting the required standards. Local audits had identified record keeping for women during labour and birth as a concern. The 2015/2016 maternity record keeping audit (February 2016) sampled 0.5% of maternity service records. Recommendations had included: improving documentation on the place of birth, the documentation of VTE antenatal, intrapartum and postnatal in the hard copy of notes. It had also been highlighted on several serious incident reviews that records were incomplete. On this inspection we found that accurate completion of documentation continued to be highlighted in incident reviews as a continuing concern. This was not on the risk register there was no obvious plan in place to ensure staff complied with hospital policy on ensuring records were completely accurate and up to date.
- At the last inspection we saw that outcomes from some incident reports had highlighted that staff were not always correctly completing CTG paperwork. Cardiotocography (CTG) is used during pregnancy to monitor both the fetal heart and contractions of the uterus. It is most commonly used in the third trimester. Its purpose is to monitor fetal well-being and allow early detection of fetal distress.
- Since the last inspection additional training had been provided for staff and recommendations that regular audits were undertaken. However, the most recent CTG audit in February 2017 highlighted there were continuing problems with CTG record keeping including incomplete documentation of risk factors, and failure to consistently comply with correct procedures for filing

CTG documents. For example, of the 30 intrapartum records reviewed 44% had no risk factors documented for CTG and 13% of the CTG were not labelled with the mother's name, hospital number or date of birth. In addition, 43% had no initial foetal baseline recorded and 30% had no CTG sticker in the notes; 57% of the audit team agreed with the reported interpretation of the CTG; however, 30% of records had no documented interpretation recorded.

- The CTG record is a legal document and failure to recognise and act on an abnormal CTG is one of the most common causes of intrapartum stillbirths and can lead to complex medico-legal issues. At the time of our inspection, it was unclear how CTG record keeping and oversight had improved as further auditing was yet to take place.
- Individual care records we reviewed were often incomplete. For example, we reviewed six maternity records; four were incomplete with loose notes. The antenatal risk assessment was not flagged on two records and three records had incomplete MEOWS (this is used to detect whether patients were deteriorating).
- Two postnatal notes had incomplete and loose papers. In one post-natal record most of the pages in the antenatal information were blank and some signatures in all the records were not legible. This was not in accordance with the trust policy.
- The audit recommended that record keeping audits to be embedded in the trust programme for 2016-2017 financial year; however, not all of these were in place for the financial year 2017/2018.
- Electronic records were available only to authorised people. Computers and computer systems used by hospital staff were password protected.
- Pre-operative checklists were competed accurately and signed and dated in accordance with trust policy.

Safeguarding

- Overall levels for compliance in safeguarding children level 1 in maternity were 95%. Compliance rate for safeguarding children level 2 training in maternity was 89%. Whereas, compliance rate for safeguarding children level 3 was 87%.
- There was a well-established midwifery team, Acorn, for supporting mothers at risk. At the last inspection we found staff understood their responsibilities and were aware of safeguarding policies and procedures. However, safeguarding adults training had been below the trust target of 90% in every department and this continued to be the case on this inspection.
- It is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training. The Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014, sets out the requirements related to roles and competencies of staff for safeguarding vulnerable children and young people. Level two training is required for all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers. Level three training is required where clinical staff work with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- All permanent staff providing direct care to pregnant women had access to safeguarding children training. Staff with no direct contact with women and babies completed level two training online. There was training for first-year trainee doctors on perinatal mental health and safeguarding.
- There was a specialist midwife and a named midwife for safeguarding. Relevant staff had attended safeguarding supervision based on the Signs of Safety model and there was a process for monitoring completion.
- Policies contained information about child sexual exploitation and female genital mutilation. We saw that the maternity and gynaecology guidelines about female genital mutilation were in place and some staff told us they had attended training. We saw evidence that cases of female genital mutilation (FGM) had been reported correctly following the FGM guidelines.
- The chief nurse of the trust had overall responsibility for safeguarding adults and children. There was a named safeguarding nurse who supported staff in the service whenever required. All staff we spoke to knew how to raise safeguarding concerns appropriately.

Mandatory training

Maternity and gynaecology

- At the last inspection we were told that a risk to patient safety had been reported on at the quality improvement board, regarding the use of CTG. This had been put in place in response to the outcome of several serious incident reviews.
- We saw that a training schedule had been implemented and ongoing training was in place with the aim of decreasing the number of incidents that may have arisen due to poor interpretation of CTG monitoring. A specialist CTG midwife assisted with CTG training and there was mandatory multi-professional team training for cardiotocography (CTG) assessment, and 'skills and drills' to rehearse obstetric emergencies.
- Staff were required to attend mandatory PROMPT training in obstetric emergencies. Training was provided for multidisciplinary groups that included consultants, staff grade doctors (such as registrars and senior house officers) junior doctors and all grades of midwives. The training included classroom sessions and simulations of events. Training was updated in four mandatory study days each year.
- Line managers monitored completion of mandatory training and overall most staff had completed their statutory and mandatory training.Training information provided by the trust in March 2017 showed that the mandatory training rate of 90% had not been met for medicines management for the antenatal unit(63%), the midwifery led unit(84%) and Larch ward(86%). 94% of staff on the labour ward had completed training. However, the majority of staff had completed basic resuscitation with the antenatal unit at 88% and the community midwifery unit at 82%. The labour ward and larch ward were above the 90% threshold for staff completing basic resuscitation training. The trust target of 90% had been met for the majority of staff in moving and handling patients.
- New staff attended a mandatory induction week that covered the mandatory training programme including basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, equality and diversity and manual handling. Staff also received training in pre-eclampsia, sepsis, maternal collapse and haemorrhage, breech presentation and shoulder dystocia. Staff all said that the training was very relevant and useful.

Assessing and responding to patient risk

- We spoke with staff and patients who told us they could have long waits in triage. Records we viewed showed that over a three day period women could wait up to four hours to see a doctor. In one night three women had self discharged due to the long waits at night. Staff told us women could wait up to six hours in the maternity assessment unit (MAU) to be seen as doctors were busy in theatres or on the wards. Staff were clear that what was needed was a dedicated doctor for triage and MAU which would help to reduce waiting times.
- All midwives were involved in the triage process. A woman could telephone or arrive on the antenatal assessment unit or labour ward, and be assessed and triaged by any of the midwives on duty. The trust policy about maternity triage had clear guidelines on the criteria of admission and treatment of women to the maternity unit. The policy was evidence based and referred to Royal College of Obstetricians and Gynaecologists guidelines regarding preterm premature rupture of membranes (PPROM), foetal movement guidelines and foetal monitoring guidelines.
- At the antenatal booking appointment, women had a full assessment of physical, social and mental health needs completed and were allocated either a consultant or midwife lead, depending on their needs. These ensured women with risk factors were seen by appropriately trained professionals.
- There had been an improvement in the number of patients with management plans in their notes (90% on larch ward compared with 59% previously). The hospital had recommended they continued to audit records with an aim to achieve 100% compliance.
- Early booking improved the chances of women receiving appropriate care. Between January to June 2017 the trust had averaged 75.5% and had not met their target to ensure that 90% of women were booked before 12 weeks.
- The trust continued to ensure that risks for women undergoing obstetric surgery were reduced as staff followed the five steps of the World Health Organisation (WHO) surgical safety checklist. We saw that checks were recorded on the electronic patient record and reviewed three records for women who had a caesarean section, which showed that checks were completed appropriately.
- Patients were monitored using the modified early obstetric warning score (MEOWS) to assess their health and wellbeing and detect signs of deterioration. Staff

were trained during induction on the use of the early warning score, enabling staff to recognise the deteriorating patient and escalate any concerns to senior staff.

- Midwifery staff completed observations on patients and babies and recorded these on neonatal early warning score (NEWS) charts. At the last inspection we saw that an audit in September 2016 showed that of a sample of 60 case notes from the pre and post-natal wards, 97% of notes had a MEOWS chart present.
- On this inspection we reviewed discharge arrangements on the postnatal ward and saw that women were regularly discharged without discharge paperwork. We saw 12 records where women had gone home without their paperwork. Staff told us this usually happened when there were no administration staff available. Mothers would be contacted and asked to come back to the ward to collect their paperwork and did not always return. If they did not come back the paperwork was sent to the GP.
- We were told that when administration staff were on leave there could be delays in uploading discharge information to the patient electronic record. This meant that if for any reason women needed to return as an emergency there was no information on the system. We were given another example of a woman ringing the postnatal ward after six weeks as they were unable to register the baby as it had not been registered on the patient electronic system.
- Administration staff ensured they checked all discharge information to ensure it was correct and followed a three way check, by checking with women, computer records and paper file that all information was correct before discharging. However, this process was not always followed when administration staff were not there. Midwifery staff told us that when they were busy, patients could be discharged quickly and paperwork did not always get completed before they went and would be left for administration staff to do when they returned. Midwifery staff were not always adhering to the trust discharge policy that patients must always be given a discharge letter detailing their treatment and any medications they may need.
- Managers told us they did not audit the discharge processes so did not know how many patients did not receive their discharge letter on the day of discharge.
- We saw that women, who had had caesarean sections were prepared for surgery, consented and had the risks of surgery explained to them. Pre-operative checklists were fully completed. This was in accordance with the World Health Organisation surgical checklist: Five Steps to Safer Surgery. We asked several patients about their experiences and they told us that they felt that they had fully understood the process, had all their questions answered and felt that they and their partners were fully involved.
- Staff had access to emergency trolleys in the event of an obstetric emergency. These were easily accessible in corridors.
- There were systems to identify women with complex social needs. staff liaised with adult social services to ensure there was an appropriate plan in place to meet the needs of women with learning disabilities

Midwifery staffing

- At the last inspection we identified that lack of staffing placed patients at risk as not every woman had been able to have one-to-one care in labour. Since then the trust had been working to recruit more staff and had increased its staffing levels, recruiting more newly qualified midwives. However, staff told us lack of staffing was still a concern due to changes in the numbers of staff allocated per shift. On the day of the inspection, the postnatal ward (larch ward) information whiteboard stated they had been short of staff for the previous 18 days.
- On this inspection we found there had been a lack of improvement in the midwife-to-birth ratio. At the last inspection we had raised concerns about staffing levels and mother-to-midwife ratio which had been 1:33. Birthrate Plus suggested that a ratio of 1:26 was appropriate for the levels of acuity as over 50% of patients were in the higher risk group because of pre-existing health issues, risk of premature or still birth, and postpartum complications. The Birthrate Plus is a tool used to determine the number of midwifery staff required to care for women based on a minimum standard of providing one-to-one care throughout established labour.
- Divisional board minutes for July 2017 showed the 1:28 threshold had not been achieved for any month between April 2016 and April 2017. With January 2017, averaging 1.33, February 1:31 and March and April 2017, 1:34. In addition, supernumerary posts were identified as required to improve safeguarding and patient safety such as delivery suite co-ordinators overnight and more

specialist midwives. The trust told us they had completed a "rapid deep dive" to "better understand opportunities for changes in skill mix and new ways of working". Managers told us they were waiting for budget changes to be made to allow them to progress these recommendations.

- A review of the service had identified that the birth rate for 2016/17 was increasing and 1.6% higher than 2015/16 and this indicated a need to recruit more staff to maintain a consistent service. Managers told us the number of midwives and health care assistants on each shift had been reduced. Most staff we spoke with raised concerns about impact on patients of the changes and several staff told us they were stressed and that there were not enough staff to cover the amount of work. We looked at incidents reports staff had completed, recording the impact on patients, including staff not being able to provide appropriate care in a timely way.
- At the last inspection the service was below their planned staff WTE target for band 7 midwifery staff. There had been a shortfall of just over 87 hours for October 2016. On this inspection, the performance dashboard reported there had been deterioration in the shortfall with 4.3 WTE (148 hours), band 7 posts and 17.8 WTE band 6 vacancies. Staff told us they were short of experienced midwives and this impacted on the amount of supervision they were able to give to less experienced staff.
- Hospital bank staff were used to cover shifts. These were mainly permanent midwifery staff already working in the hospital or in the community, working additional hours. Rotas we saw for five days, including weekends, showed that between eight and thirteen bank staff were used to cover shifts over a 24 hour period. This meant that on some shifts a large majority of staff were hospital bank staff. Agency staff were discouraged due to financial implications.
- Staffing rotas showed bank staff were used for over 40% of days in the central delivery suite (CDS). If the lead midwife identified a risk, the trust escalation policy required them to contact the on-call manager. However, we continued to hear from staff and saw on incident reports that managers were sometimes unavailable to respond to this identified risk.
- At the last inspection midwives had said they did not always take breaks and often worked beyond the end of their shift. During this inspection staff said there had been improvements in some areas; for example, on Larch ward, where managers were supportive in encouraging them to take breaks. However, we saw several incident reports identifying there were continuing issues of staff unable to take breaks in the labour ward and midwifery birthing unit.
- Staff told us that due to staff shortage not all mothers received one-to-one care while in the first stages of labour. They told us it was one midwife to two mothers and sometimes more. Staff did their best to ensure they provided the best care; however, several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly. For instance, prioritising one-to-one care of women in labour meant there was a risk that other women on other wards did not receive appropriate care. We saw an example of an incident where deterioration in the mother and baby's condition that had not been identified as quickly as it could have been.

Medical staffing

- During the last inspection in November 2016 we identified there were risks associated with gaps in consultant presence on the labour ward.
- On this inspection we found there had been an increase in consultant cover to 98 hours. Data provided by the trust showed that consultant cover on the labour ward had reached its full 98 hours from September 2016 onwards. However, this was not necessarily a physical presence on the maternity unit as the consultants would be responsible for other areas of the maternity and gynaecology service at the same time. Staff told us that where variations in cover did occur, this was because consultants were on leave, sick or otherwise not available to cover shifts.
- Staff told us this meant patients were waiting longer for treatment. In response to the previous inspection findings the trust were planning to separate obstetrics and gynaecology staff rotas to enable obstetric consultants to be available for the labour ward.
- Clinical staff worked a variety of shifts and several chose not to work out of hours which increased pressure on other staff. The service was aware of this risk and was monitoring the position. The trust had not approved the proposal to fund additional permanent consultant posts at the time of our inspection, locum staff were used to cover gaps wherever possible.

- Between 10pm and 8am there was no consultant physical presence at night other than two nights a week. For five out of seven nights there was no consultant presence in the hospital and consultants were available by phone and covered for each other whenever they were needed. Several staff said the volume of work was unremitting and staff were very tired and doing all they can to support their colleagues and be there.
- A system was in place for providing locum doctors with an appropriate induction.
- Out-of-hours medical cover at all levels was overstretched, leading to delays in care. The medical rotas and cover for the labour wards showed that emergency and on-call cover was provided by different grades of doctor.
- At the last inspection we found staffing issues potentially impacted on women receiving timely pain relief. This continued to be the case. Staff told us that an anaesthetist was not always available to promptly respond to a woman in labour due to other demands, especially overnight. This meant that some women had to wait longer than 45 minutes for an epidural anaesthetic when in labour. Safer childbirth recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 states, "When women choose epidural analgesia for pain relief in labour they should be able to receive it within a reasonable time ... the response time should not normally exceed 30 minutes and must be within one hour, except in exceptional circumstances".
- Obstetric anaesthetic cover consisted of two anaesthetists between the hours of 7am and 7pm Monday to Friday; one anaesthetist covered the night and weekends, supported by a second anaesthetist who covered surgical emergencies. In addition, a third anaesthetist on-call consultant was available.

Theatre staffing

- There was a dedicated theatre team for one of the obstetric theatres. This included a consultant anaesthetist from 7am to 7pm on weekdays and a consultant on call from home after 7pm weekdays and weekends, as well as 24-hour staff-grade cover.
- There was not a full second theatre team even though the second theatre was often in use. When a second theatre was needed, staff called on the hospital's emergency theatre team. Midwives we spoke with were concerned by the lack of a dedicated second theatre. They said getting theatre staff could be a problem and was dependent on the theatre and theatre staff not being needed for operations in other departments. This meant mothers had to wait longer for operations if one theatre was already in use. In one example we saw the patient had come in for an elective caesarean. They had been nil by mouth since 9am and were not able to go to theatre until 4.40pm as the theatre was needed for emergencies. At the last inspection we were told a business case had been prepared for more theatre staff and a dedicated second theatre. Since then there had been no progress and the situation for women remained the same.
- As commented on in the last inspection there was only one operating department practitioner (ODP) for the delivery suite. This meant midwives had to call on ODPs from the main theatres for epidurals, delaying pain relief for some women.

Major incident awareness and training

- The trust had an incident response plan. This was a trust wide document that included a 'Maternity Escalation, Unit Closure and Business Continuity Plan'. This was a clear plan to manage high levels of patient activity and times when the maternity unit was full to capacity. Roles and responsibilities were clearly defined and processes for decision-making identified.
- The hospital had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and business continuity plans ensured the delivery of the service was maintained.
- All staff had access to annual fire training and midwifery staff explained the evacuation procedure for maternity wards. Managers assured us all maternity staff were up to date with annual fire training and training data we saw confirmed this. Safety checks on fire extinguishers and emergency lighting had taken place at regular intervals.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

Maternity and gynaecology

- Whilst some progress had been made against the previous requirement notice for governance, there was still a need to improve and strengthen governance structure and reporting systems.
- There continued to be concerns about the categorising and time taken to complete incident reports and serious case reviews.
- Systems were not effective in monitoring the outcomes of audits and incident reports. We found that incomplete patient records was an ongoing problem. However, there were no clear action plans in place to regularly audit or monitor progress to improve the quality of documentation.
- There were inconsistencies in information presented for purposes of monitoring the quality of the service, which meant we could not be assured that performance information was accurate or up to date.
- We saw plans to monitor and drive improvements throughout the maternity service, however progress was slow and some of these plans had not yet been implemented.
- Whilst staff felt managers were aware of the staffing difficulties, they were less aware of the challenges and impact on the care they were able to provide due to staff shortages and lack of experienced staff.

However, we also found:

- Although some difficulties remained in gaining the support of midwifery staff affected by changes the trust had imposed, morale among some midwives had improved since the last inspection.
- The trust had made progress in revising the governance team structure for women's services, and improving governance leadership.
- Most staff commented there had been improvement in communication since the last inspection, with the leadership team being much more visible.
- There was a clearly defined overarching strategy for the maternity service, although there were varying degrees of awareness of the future plan from ward staff we spoke with.

Leadership and Culture of service

- The chief nurse was the designated board member for maternity services. The director of midwifery role was responsible for maternity services at Newham, as well as Royal London Hospital and Whipps Cross University Hospital. The director of midwifery reported to the trust's chief nursing officer.
- The hospital was responsible for day to day management of the maternity and gynaecology service. There was a women's clinical board, and both a perinatal clinical and a gynaecology clinical network reporting to it. These were responsible for vision, strategic direction and standardisation.
- At the last inspection staff had told us that generally the maternity unit was a welcoming and friendly place to work; however, not all staff had agreed. On this inspection we received a mixed response with several staff commenting that morale was low and stating they were not involved in decisions being made about changes to staffing levels and shift patterns. Staff felt the changes were based on financial decisions and the need to save money and had not looked at the impact on patients. As well as the concerns that were raised, most staff commented there had been improvement since the last inspection with the leadership much more visible and visiting the units on a regular basis.
- Doctors in training said consultants were supportive and accessible. They were encouraged to ask questions and felt they were receiving good quality training. One doctor told us they felt the training was "excellent" and the clinical and midwifery team were very supportive of doctors in training.

Vision and strategy for this service

- There was a clearly defined overarching strategy for the maternity service. The trust's maternity review had proposed plans to transform maternity and newborn care services for women. This included ensuring women had 'continuity of care, with a named midwife' and 'developing a culture that empowers midwives'.
- Senior leaders were aware of the vision, including plans to work with other providers to offer maternity services across combined localities, thus offering women more choice of providers to meet their needs. There were varying degrees of awareness of the future plan among the ward staff we spoke with, particularly more junior staff.

Governance, risk management and quality measurement

Maternity and gynaecology

- Following introduction of the leadership operating model at the Newham University Hospital site responsibility for risk registers had been devolved to local management. At the last inspection we saw that the trust had realigned the risk registers as although some risks had applied to all trust sites, some were site specific but combined for a trust wide view with cross site owners. The service had been aware they had gaps on the risk register and had been in the process of reviewing all risks on the register. On this inspection we saw there continued to be gaps in the site risk register Overdue actions for incident reports and SIs were not included as a risk on the maternity risk register.
- The trust had made progress in revising the governance team structure for women's services, and progress on improving governance leadership with a new obstetric lead for clinical governance appointed in May 2017. Monthly local governance meetings were held within the maternity and gynaecology service, where risks were discussed and ratings agreed. This was then approved by the hospital's site executive team.
- At the previous inspection, security had been identified as a risk because of insufficient staff to monitor access to the postnatal and labour wards. During this inspection, we found some improvements had been made to baby security and reception staffing. Work was in progress to ensure entrances in all the areas where babies were cared for were secured and expected to be completed by September 2017. However, we were able to enter and exit wards without being challenged or observed. We informed the trust and additional measures were put in place and staff were made aware of their responsibilities in this area to ensure mothers and babies were kept safe from unauthorised access to the units.
- At the last inspection there were concerns about the categorising and length of time the trust took to complete incident reports and serious case reviews (SIs). On this inspection we found there had been some progress with approval in June 2017 to establish a monthly governance dashboard to review complaints, incidents and SIs; however, this was not yet in place.
- The trust action plan stated all "SIs should be escalated and reported within the timeframes" and "all incidents reviewed and investigated within trust timeframe of 14 days". The trust reported that as of May 2017 there remained 63 incident actions overdue and they had set a date of September 2017 to meet this target.
- We reviewed five overdue serious incident reports dating from November 2016 that had not yet been reported on. The trust's adverse incident policy followed NHS England guidance in stating there was a maximum 60 working day deadline for reporting on and submitting to commissioners. The service was not consistently meeting this target and there were concerns about the ongoing processes for managing incidents and the lack of evident assurance that learning was properly followed up and embedded.
- The trust did not have effective systems in place to monitor the outcomes of audits. At the last inspection serious incident reviews and incident reports had highlighted incomplete patient records as an ongoing problem. We reviewed incident reports and continued to see incomplete documentation being repeatedly raised as an issue.
- At the last inspection the quality improvement board had reviewed staff practice in the use of CTG. And in response, a rolling training schedule had been implemented with the aim of decreasing the number of incidents that may have arisen due to poor interpretation of CTG monitoring.
- However, in February 2017 a cardiotocography (CTG) audit had assessed antenatal, intrapartum and postnatal case note documentation. The audit identified incomplete documentation as a theme and this was not on the risk register. This was important as its purpose is to monitor fetal well-being and allow early detection of fetal distress. There was no action plan in place to monitor or improve the quality of documentation which meant there were potential risks of incidents being repeated.
- The quality improvement board met every two months and had participation from relevant stakeholders and commissioners. We saw plans were in place that were being monitored to drive improvements throughout the maternity service, however progress was slow. There were goals, action plans and regular reviews of the service improvement plans by managers, however several of these had not yet started. Managers told us start dates had been delayed because they were still in the process of allocating to relevant managers. Several managers said they had a number of competing responsibilities and concentrated on supporting staff and ensuring patients had adequate care and support which left limited time to do additional work.

- There was inconsistency in documents presented at these meetings relating to monitoring the quality of the service which meant we could not be assured that performance information collected was accurate or up to date. Birth to midwife ratios were not consistent in all documents we viewed. The May 2017 divisional performance report stated that maternity services were not meeting the 1:28 ratio and suggested they were performing at 1:34 and in one case 1:38 whilst other minutes of meetings stated they were meeting the 1:28 target.
- In response to concerns raised at the last inspection about the consultant cover for women on the labour ward managers told us they had organised a peer review of obstetric consultant hours from a senior obstetrician from another large, London maternity unit. They had appointed an external consultant to review all consultants' job plans and service improvement plans. Managers told us the review had confirmed that the number of consultants working at the hospital was correct. The peer review recommended the separation of obstetrics and gynaecology rotas to ensure dedicated labour ward cover.
- The clinical commissioning group provided funding for the maternity voices partnership (MVP) for the London Borough of Newham. This met quarterly. We saw evidence of the MVP's contribution to the service, such as providing feedback from women, with actions identified by the maternity service.

Public and Staff engagement

- During the previous inspection we saw that mechanisms for communicating with maternity staff were top down rather than two way. During this inspection we found similar themes with staff feeling under pressure due to the volume of work and communication, most still feeling it was top down although several staff felt there had been some improvement.
- The staff we spoke with were aware of the trust's Listening into Action programme to improve staff engagement. Staff told us they valued the opportunity to raise concerns.
- Trust wide we saw that work had progressed on an action plan to respond to negative feedback and to monitor progress in improving the patient experience.

Innovation, improvement and sustainability

- The midwifery team won the Royal College of Midwives Euro King Better Births award in March 2017. This award recognised their work to give local women improved choice about where to give birth and empower midwives to provide continuity of care throughout women's journey.

Outstanding practice and areas for improvement

Outstanding practice

- The midwifery team won the Royal College of Midwives Euro King Better Births award in March 2017. This award recognised their work to give local women improved choice about where to give birth and empower midwives to provide continuity of care throughout women's journey.

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Take steps to ensure sufficient numbers of appropriately skilled staff are deployed to meet the needs of the service.
- Ensure that women receive timely treatment and pain relief, and that out of hours medical cover is effective in responding to and meeting the changing needs and circumstances of people using the service.
- Ensure all overdue serious incident reports are reviewed, actions are completed, learning is disseminated in a timely way, and processes are in place to effectively monitor progress.
- Ensure learning from incidents is used for the purposes of continually evaluating and improving services.
- Ensure that patient records, including cardiotocography (CTG) documentation, are comprehensively and consistently completed and that processes are in place to evaluate this.

Action the hospital SHOULD take to improve

The trust should:

- Ensure processes are properly utilised so that mothers and babies are kept continuously safe from unauthorised access to the units.
- Ensure delivery suite coordinators have supernumerary status with sufficient allocated time and resources to carry out their oversight and support role.
- Further consider funding for staffing a second obstetrics theatre to improve waiting times for caesarean.
- Take further action to ensure consistent compliance with the trust's target of 90% completion of mandatory training, including safeguarding training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing Although there had been some staff recruitment there continued to be shortages of midwifery staff at the time of our inspection. This included a shortfall in the number of experienced midwives. Several staff told us that the lack of appropriately skilled midwives meant they were often spread thinly and this could impact on women's care. At the previous inspection the service was below their planned staff whole time equivalent (WTE) target for band 7 midwifery staff. There had been a shortfall of just over 87 hours for October 2016. On this inspection the performance dashboard reported there had been deterioration in the shortfall with 4.3 WTE (148 hours), band 7 posts and 17.8 WTE band 6 vacancies. On this inspection we found an improvement with consultant cover increased to 98 hours. However, staff continued to raise concerns and told us their continued to be delays with women waiting longer for pain relief and treatment due to anaesthetists being busy elsewhere and not able to attend when requested. Out of hours medical cover at all levels was overstretched, leading to delays in care. **This was a breach of Regulation 18 (1)**

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Trust guidelines for the reporting of serious incidents and root cause analyses were being followed. However, there remained concern about the categorising and length of time the trust took to complete incident

Requirement notices

reports and serious case reviews. Despite improvements, targets were not being met and there were concerns about under-reporting and the processes for managing incidents. There was a lack of evident assurance that learning was properly followed up and embedded.

There was inconsistency in documents presented to quality improvement meetings relating to monitoring the service, which meant we could not be assured that performance information collected was accurate or up to date. For example, birth to midwife ratios were not consistent in all documents we viewed. The May 2017 divisional performance report stated that maternity services were not meeting the 1:28 ratio and suggested they were performing at 1:34 and in one case 1:38 whilst other minutes of meetings stated they were meeting the 1:28 target.

At the last inspection we had raised concerns about record keeping. The most recent cardiotocography (CTG) audit in February 2017 highlighted there were continuing problems with CTG record keeping, including incomplete documentation of risk factors, and failure to consistently comply with correct procedures for filing CTG documents. The trust had introduced measures to address the issues raised; however, it was unclear how CTG record keeping and oversight had improved as further auditing was yet to take place.

This was a breach of Regulation 17(1), 17(2)(a)(c)(f)