Barts Health NHS Trust

The Royal London 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

The Royal London Hospital in Whitechapel, East London is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

It provides maternity and gynaecology services to the population of Tower Hamlets in east London. The hospital also provides specialist maternity services to women from other hospitals within the Barts Health NHS Trust, and fetal medicine to women from a wider geographical area. The unit delivers over 5,000 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 January 2015 and July 2016 respectively. Gynaecology services were not inspected on this visit.

Our key findings were as follows:

- Staff told us that cultural issues identified in 2015 continued to have a negative impact on patients and staff. Although some managers were taking action to address bias and unprofessional behaviours they felt that changes were not rapid or effective enough.
- Not all systems to identify, manage and capture risks and issues had improved. Mother and baby security had been identified as a risk in 2015 and although improvements had been made in physical security, it was not always effective in preventing unauthorised access to the delivery suite Staff told us unauthorised people were still able to access wards.
- Arrangements for governance and performance management did not always operate effectively. There remained inconsistencies in the way some data was collected and reported, which impacted on its accuracy and reliability. The service did not always follow trust policy on incident reporting, categorisation and ensuring outcomes were promptly actioned. Systems were not always effective in monitoring the outcomes of incident reports.
- Improvements had been made to staffing levels and there were enough midwives on wards during the day and at night. However, the number of clinical midwives was still below establishment. This resulted in inefficiencies on the delivery suite and the postnatal ward and meant some women did not get timely care. Consultant cover on the labour ward averaged 81 hours per week between November 2016 and April 2017, which was below the trust target of 98 hours.
- Communication between managers and maternity staff and midwives, which had deteriorated at previous inspections, had improved. The majority of staff were positive about changes, but they identified some cultural issues and ineffective management styles as barriers to change.
- In September 2016 we followed up on serious concerns about baby security identified on inspection in July 2016. A system to ensure that all mothers and babies had name bands had lapsed only two months after implementation. During this inspection we saw improvements had been made. All mothers and babies were wearing name bands and staff made twice daily checks which were recorded. We viewed three months of audit records which confirmed this.
- Women who had given birth at the hospital's birth centre were very happy with the way staff treated them, and appreciated the continuity of care they had from midwives. However, we otherwise received a mixed response from women and their partners. Some women and families we spoke with reported poor experiences that included not being treated with dignity and respect and having no continuity of care.
- All of the clinical areas we visited were visibly clean and well maintained, with display boards detailing cleanliness and safety information.
- There were specialist teams to support women who may require additional support or those with specific needs.
- Some systems to identify, manage and capture risks and issues had improved. A site specific maternity risk register was in place. Action plans to address concerns from previous inspections had mitigated and reduced some risks.

Summary of findings

Outstanding practice included:

- My Body Back maternity clinic was set up with project volunteers for women contemplating pregnancy or who are pregnant. It was a charitable voluntary service for women who had experienced rape and sexual trauma. The clinic provided advice about pregnancy and birth by empowering women to develop their birth plans and strategies in preparation for labour and birth.
- The service had won an award for the use of manual and vacuum aspiration enabling miscarriage to be managed under local anaesthetic without needing to go to theatre. This reduced waiting times and uncertainty for women.

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

Importantly, the trust must:

- Ensure all security systems and processes are properly utilised and staff are aware of their responsibilities in this area to ensure mothers and babies are kept safe from unauthorised access to the units.
- Review all overdue serious incident reports and ensure that all required actions are completed and learning is disseminated in a timely way.
- Ensure governance processes for monitoring and reviewing serious incidents are applied correctly so that serious incidents are addressed in a timely way in future.
- Ensure there are sufficient numbers of experienced midwives to supervise and support less experienced staff and safely manage the level of acuity of women on the labour and postnatal wards.
- Ensure that all relevant staff complete children and adult safeguarding levels two and/or three to ensure compliance with the trust target of 90% completion.
- Ensure that the level of consultant cover on the delivery suite meets the trust target of 98 hours.

In addition the trust should:

- Consider introducing the NHS maternity safety thermometer to more accurately assess risk specifically associated with maternity care.
- Ensure delivery suite coordinators have supernumerary status with sufficient allocated time and resources to carry out their oversight and support role.
- Take further action to ensure compliance with the trust's target of 90% completion of mandatory training.
- Consider auditing the percentage of women presenting in labour seen by a midwife within 30 minutes so as to be better assured that all women are appropriately risk assessed and seen by the relevant professional in a timely way.
- Assess demand for written information in languages other than English.
- Take further action to address the perceived culture of bullying and harassment amongst midwives.
- Take further action to improve cultural awareness of staff.

Professor Ted Baker
Chief Inspector of Hospitals

The Royal London Hospital

Detailed findings

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Detailed findings

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Our ratings for this hospital

Our ratings for this hospital are:

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

Maternity and gynaecology

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

Information about the service

The Royal London Hospital (RLH) is part of Barts Health NHS Trust. It provides maternity and gynaecology services to the population of Tower Hamlets in east London. The hospital also provides specialist maternity services to women from other hospitals within the Barts Health NHS Trust, and fetal medicine to women from a wider geographical area. The unit delivers over 5,000 babies every year, and numbers are increasing each year.

The maternity unit has a 31 bedded delivery suite, two obstetric theatres and an obstetric high dependency unit on the sixth floor of the hospital. The postnatal ward on the eighth floor has 31 beds and cots. Antenatal clinics are also on this floor. The maternity unit is supported by a 'level 3' Neonatal Intensive Care Unit (NICU) for babies needing respiratory support.

There are two midwifery-led units: A co-located 'Lotus' birth centre which is on the eighth floor at RLH and The Barkantine Centre which is located on the Isle of Dogs in east London. We did not visit The Barkantine Centre during this inspection.

Both of the midwife-led units are staffed by midwives using an integrated model of care. This means that as well as core staff, midwives from the community teams are integrated into the birth centres to provide continuity of care for women. Women can also choose a home birth supported by community midwives.

All women attend the hospital for their first antenatal appointment and ultrasound scans. Most women attend antenatal clinics run by community midwives in health centres and local GP surgeries. Specialist antenatal clinics at the hospital are run for women whose health conditions need additional specialist input, for example those with mental health support needs, heart, kidney or neurological conditions. Postnatal clinics are run in the community and at the birth centre.

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

During our inspection, we visited the Lotus Birth Centre, labour and postnatal wards, including triage, high dependency unit, antenatal clinics, the early pregnancy assessment unit and operating theatres.

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

We observed care and treatment and looked at five care and medical records. We received comments from women using the service who told us about their experiences. We also reviewed performance information about the maternity service.

We spoke with over 25 individual members of staff during the inspection, as well as other staff in joint meetings and staff focus groups before the inspection. This included midwives, consultant obstetricians, nurses, maternity support workers, managers, administrators, receptionists and domestic staff. We spoke with six women and family members. We observed patient care, staff interactions, the availability of equipment and the environment. We

reviewed written information provided by the trust. We considered formal arrangements for audit and the management of risk to evaluate the governance arrangements.

We did not inspect gynaecological services on this inspection.

We did not inspect termination of pregnancy services.

Summary of findings

We rated the maternity service as 'requires improvement' overall. We rated the maternity service as 'good' for effectiveness, 'requires improvement' for safe, caring, responsive and well-led. This is because:

- Staff told us that cultural issues identified in 2015 continued to have a negative impact on patients and staff. Although some managers were taking action to address bias and unprofessional behaviours they felt that changes were not rapid or effective enough.
- Not all systems to identify, manage and capture risks and issues had improved. Mother and baby security had been identified as a risk in 2015 and although improvements had been made in physical security, it was not always effective in preventing unauthorised access to the delivery suite. Staff told us unauthorised people were still able to access wards.
- Arrangements for governance and performance management did not always operate effectively. There remained inconsistencies in the way some data was collected and reported, which impacted on its accuracy and reliability. The service did not always follow trust policy on incident reporting, categorisation and ensuring outcomes were promptly actioned. Systems were not always effective in monitoring the outcomes of incident reports.
- At our inspection that took place in September 2016 we found some staff were not aware of the trust's infant abduction policy. During this inspection staff we spoke with were clear on the process they needed to follow in the event of abduction. However, the policy referenced the use of an electronic baby tagging system which was not in use at the time of our inspection.
- At our inspection that took place in September 2016 the level of consultant cover on the delivery suite had increased from 71.5 hours per week to 81 hours. During this inspection we found the service had not met its target to ensure they provided 98 hours consultant presence on the labour ward, averaging 81 hours per week between November 2016 and April 2017.
- At the time of our last inspection the hospital had a backlog of reported incidents waiting for action to be

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completed. On this inspection we found the backlog had significantly reduced. However we saw that incidents could show as closed on the quality assurance incident database even though outstanding actions were still to be completed. It was unclear how these were followed up and how the trust assured actions were completed.

- Staff were provided with information about some incidents through newsletters and memos from the hospital governance team. However, some staff said that feedback to individuals who reported incidents was not always provided. Feedback from incidents to staff who had not been directly involved was variable.
- We found medical notes for women and babies were inconsistently completed, particularly the handover to post-natal care and notes on the postnatal ward.
- In September 2016 women we spoke with reported inconsistent experiences in the maternity service, some very poor. Some women and partners reported a lack of respect from midwives. During this inspection we received a mixed response from women and their partners. Women's reported experience of care was mixed. Some women and families we spoke with reported poor experiences that included not being treated with dignity and respect and having no continuity of care. They felt some staff focused purely on tasks rather than treating people as individuals.
- A Tower Hamlets Healthwatch trends analysis report highlighted patient comments on staff attitude were 'broadly negative'. With the exception of clinical treatment, which received mixed reviews, responses to most aspects of the care pathway were negative. 85% of the trust's responses were from women being treated at the Royal London Hospital.
- The system of dual risk registers for hospital site and cross-site maternity risks was confusing and did not provide clarity and transparency for managers around all service risks. However, some systems to identify manage and capture risks and issues had improved with the introduction of a site specific maternity risk register.
- Women experienced waits for care throughout their maternity experience. Senior staff were aware of delays to discharge from the postnatal ward but this had not been audited.
- Improvements had been made to staffing levels and there were enough midwives on wards during the day and at night. However, the number of clinical midwives was still below establishment. This resulted in inefficiencies on the delivery suite and the postnatal ward and meant some women did not get timely care.

However:

- Communication between managers and maternity staff and midwives, which had deteriorated at previous inspections, had improved. The majority of staff were positive about changes, but they identified some cultural issues and ineffective management styles as barriers to change.
- Midwives told us there had been some improvements since the last inspection. Midwives felt they were listened to and morale had improved. Changes had been made to staff rosters to ensure staff knew their working patterns in advance.
- In September 2016 we followed up on serious concerns about baby security identified on inspection in July 2016. A system to ensure that all mothers and babies had name bands had lapsed only two months after implementation. During this inspection we saw improvements had been made. All mothers and babies were wearing name bands and staff made twice daily checks which were recorded. We viewed three months of audit records which confirmed this.
- At the last inspection the delivery suite coordinator was not 'supernumerary' to the staffing rota and therefore was not always able to provide the oversight of the delivery suite necessary to support staff and manage capacity. There had been significant progress with agreement for additional posts since the last inspection.
- Additional capacity for midwife-led birthing was introduced in November 2016. This had reduced pressures on space in the labour ward.

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- All of the clinical areas we visited were visibly clean and well maintained, with display boards detailing cleanliness and safety information.
- Women who had given birth at the hospital's birth centre were very happy with the way staff treated them, and appreciated the continuity of care they had from midwives.
- Clinicians planned and managed care in line with current evidence based guidance, standards and best practice.
- Women described good support around their choice of place of birth, including home births, and partners were welcome to stay.
- Perinatal bereavement care was sensitive and appropriate.
- There were specialist teams to support women who may require additional support or those with specific needs.
- Some systems to identify, manage and capture risks and issues had improved. A site specific maternity risk register was in place. Action plans to address concerns from previous inspections had mitigated and reduced some risks.
- Secure archiving for ultrasound scans was in use in some areas. It had been planned to be available throughout the maternity and gynaecology service by autumn 2016 however, difficulties with computer systems had delayed its availability.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as 'require improvement' because:

- Although improvements had been made in physical security to the maternity areas of the hospital, including swipe card access and increased receptionist cover, it was not always effective in preventing unauthorised access to the delivery suite and post-natal ward.
- The hospital had a backlog of reported incidents waiting for action to be completed. We saw that incidents could show as closed on the quality assurance incident database even though outstanding actions were still to be completed. The trust was aware they had a backlog, however it was unclear how these were followed up and how the trust assured actions were completed.
- Records were not always stored securely. We found records were left unattended and in some instances patients' sensitive personal information was easily accessible and could be viewed or removed by unauthorised people.
- A bi-annual infection prevention and control audit in March 2017 highlighted staff non-compliance with the trust's uniform policy. Areas for improvement included concerns about staff understanding and knowledge of responsibilities. It was unclear who was responsible for overseeing or implementing changes, and when this would be achieved as the action plan was incomplete.
- Safeguarding adults training levels were well below the trust target and did not meet the required standards.
- The service had not met its target to ensure the provision of 98 hours per week consultant presence on the labour ward. The service averaged 83 hours between November 2016 and April 2017.
- The delivery suite coordinator was not always 'supernumerary' to the staffing rota and therefore was not always able to have the constant oversight of the delivery suite necessary to manage capacity and support staff, particularly new staff.

However:

- The hospital had systems for reporting, investigating and acting on incidents and serious adverse events.

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- All of the clinical areas we visited were visibly clean and well maintained with display boards detailing cleanliness and safety information.
- The was an escalation process in place for staff to follow for deteriorating women and systems for ensuring observation of women's vital signs were in place.
- Sepsis management had been reviewed and effective protocols were in place.

Incidents

- There were no never events reported by the service in the year preceding our inspection. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff were provided with information about incidents through newsletters and memos from the hospital governance team. However, some staff said that feedback to individuals who reported incidents was not always provided. Feedback from incidents staff had not been directly involved in was variable and they did not always get to hear the outcome of incident investigations.
- Between December 2016 and May 2107 there were 81 'near misses' reported and nine serious incidents in the maternity service. All of the senior team in maternity and gynaecology received copies of reported potential serious incidents (SIs) to ensure there was good awareness amongst managers.
- At the time of our last inspection the hospital had a backlog of reported incidents waiting for action to be completed. On this inspection we found the backlog had significantly reduced. However we saw that incidents could show as closed on the quality assurance incident database even though outstanding actions were still to be completed. It was unclear how these were followed up and how the trust assured actions were completed.
- We found the level of incident reporting had increased since our previous inspection which indicated a good reporting culture. For the period April 2015 to March 2016, 991 clinical and non-clinical obstetric incidents were reported. Between December 2016 and May 2017 (six months) 829 incidents were reported. Clinicians said they received feedback and weekly meetings took place where incidents were discussed. The top five incident themes were communication, obstetric haemorrhage, staffing, delays in care and unanticipated admissions to NICU.
- Anaesthetic incidents were displayed on the wall of the anaesthetic office as 'Learning Points of the Week'. These were mentioned in the daily safety briefing which also covered new protocols and new equipment. We saw evidence of follow up of obstetric anaesthetic episodes.
- Safety huddles were an MDT meeting where various members of the team came together on a daily basis to verbally share safety and operational risk issues on the unit. These linked into the safety huddles that took place across the hospital. However, not all staff were present for the huddles because of their shift patterns and work demands. The trust told us that they were not intended for all staff to attend and that attendance was dependent on clinical work load of individuals and the department as a whole.
- Incidents in maternity services were reviewed at a weekly multidisciplinary risk forum which identified potentially serious incidents or other incidents requiring the involvement of a consultant. A supervisor of midwives attended the maternity meeting and took part in the investigation of complaints and incidents where appropriate.
- The hospital shared learning more widely, in relevant cases, through NHS England, the pan-London obstetric network and through the Supervisors of Midwives network.
- Mortality and morbidity meetings were held regularly, and doctors gave presentations on specific cases. It was not clear how learning was drawn from these meetings to influence future practice, because no minutes or action plans were recorded.
- Staff were aware of actions they should take when a 'reportable patient safety incident' occurred and assured us 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 duty of candour.

- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence these were shared with the relevant managers.

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 NHS maternity safety thermometer, designed for use in maternity care, was not used by the hospital. This meant that women did not readily see the harms specifically associated with maternity care such as rates of perineal or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.
- The maternity department had systems in place for recording and monitoring safety performance. A dashboard was used to rate performance against key safety indicators. Performance was colour coded as red, amber or green to enable management to see at a glance areas that required improvement. The maternity dashboard was on display on the postnatal ward. While it was helpful to make this data publicly available, this tool was primarily designed for professionals and was not easy for women to understand, especially those who did not speak English as a first language.
- Maternity information collected included, the percentage of inductions of labour, number of caesarean section deliveries and complications of labour and delivery, number of stillbirths and breech births.
- Caesarean rates varied between 20.9 % in November 2016 to 16.9% in May 2017. This was worse than the England average of 15.2%. Information on the number of women that had their labour induced was not available.
- The service had not met its target of 100% for women assessed by midwives and obstetricians for risk of venous thromboembolism (VTE).The monthly compliance percentage varied from 76.2% in January 2017 to 93.6% in April 2017. Reminders were included in safety updates for staff to assess all women for VTE risk and paperwork and processes were being reviewed. Senior managers were monitoring audit outcomes to improve compliance with this performance measure.
- There was a process in place for reviewing all deaths including stillbirths through the hospital's mortality and morbidity processes. Between April 2016 and March 2017 there had been 13 neonatal deaths and 47 ante-partum stillbirth.
- There were no closures of the maternity unit between November 2016 and March 2017, however the service had been suspended in December 2016, and there had been five attempts to suspend services in November and December 2016 due to pressures on the service.

Cleanliness, infection control and hygiene

- All of the clinical areas were visibly clean and well maintained on inspection.
- We saw 'I am clean' stickers used appropriately on equipment and the stickers we looked at recorded the correct day's date to indicate a clinical item was ready to be used again, in all the areas we visited.
- Domestic staff in the maternity areas followed cleaning schedules on required cleaning standards, practices and frequency of cleaning.
- Arrangements were in place for safe disposal of waste and clinical specimens**.** Waste management was compliant with national guidance: DH Health Technical Memorandum 07-01: Safe Management of Healthcare Waste (2011).
- The Patient-Led Assessment of the Care Environment (PLACE) report for 2017 concluded that the cleanliness of the maternity environment supported good care.
- We observed staff adhered to the trust's 'bare below the elbow' policy which meant standards of hygiene were maintained.
- Personal protective equipment such as aprons and gloves, and hand washing facilities were available for staff to use. We observed two staff using personal protective equipment appropriately, which was in line with national guidance: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- Hand sanitising gel was placed on reception desks at the entrance to clinics or wards. We saw that reception staff were proactive in reminding visitors to use it, but

there were no signs encouraging people to use it. Dispensers were not always placed in positions to make their use obvious. Hand sanitising gel was available within the clinical areas.

- A bi-annual infection prevention and control audit in March 2017 for Ward 6F highlighted staff non-compliance with the trust's uniform policy. The ward scored 72% against a trust target of 90%. The audit for ward 6D highlighted similar concerns with a score of 81%. Areas for improvement included concerns about staff understanding and knowledge of responsibilities. For example, some staff were not aware where general cleaning checklists were and were observed not complying with the uniform policy, for example wearing jewellery. Actions were recorded, however it was unclear who was responsible for overseeing or implementing changes, and when this would be achieved. The action plan was incomplete.
- We saw that although hand hygiene audits had not been carried out routinely in the past, these were now being done and showing high scores, above the trust target of 90%. Maternity staff we spoke with knew the birth pool cleaning procedures.
- On the previous inspection there had been incidents of sepsis in maternity, and the hospital had been identified as an 'outlier' in this area by the CQC. In response to this we saw that the trust had run a 'Know Your Sepsis Six' campaign (sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of people with sepsis). The obstetric infection guideline acted as the maternity sepsis guideline. The aim of this policy was to facilitate early identification of infection and initiation of appropriate and timely antimicrobial therapy to prevent sepsis and adverse maternal and fetal /neonatal outcomes. The maternity wards, including the maternity HDU, had sepsis trolleys containing folders with guidance on recognition and a management proforma, which meant that everything needed to treat sepsis promptly was readily available. Trust policy stated that patients with signs of sepsis should have senior review, and those with severe sepsis should have a critical care review.
- There were policies for screening and treatment of C-difficile and MRSA infections and no reported infections of either MRSA or C-difficile within the service.
- The service had an annual infection prevention and control programme of work for 2016/17. This showed the service had a plan for continuous improvement in the management of infection prevention and control. It highlighted the importance of accountable leadership, multi-agency working and the use of monitoring systems.
- All staff were required to complete infection control levels one and two mandatory training. Level three infection control training was mandatory for midwives and nurses. Records showed that only 66% of staff on ward 8E, 57% of community midwives, 60% of postnatal staff and 78% of staff on ward 6 E and F Had completed mandatory training, below the trust target of 90% for five of the previous six months.

Environment and equipment

- The delivery suite had 31 rooms which were all equipped for women to give birth. Many of the rooms were not used for delivery. Some were used for women and babies after birth as an extension of the postnatal ward and others for antenatal women. The unit was divided into a midwife-led low risk area (6E) and an obstetrician-led high risk area (6F).
- The midwife-led area had 14 beds which included two triage rooms, an early labour lounge and four rooms for induction of labour. If the unit was full, midwives offered women the choice of going to another hospital site within the trust, but we were told the uptake of this was low. Women in this situation were asked to attend the day assessment unit to have a cardiotocography (CTG). This is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy to enable staff to make a treatment plan.
- Wards were accessible to patients and visitors with limited mobility. There were disabled toilets and shower facilities and accessibility rails on walls.
- The high risk area (ward 6F) adjoined the two obstetric theatres. The obstetric theatres were large and well equipped.
- All equipment had in date evidence of electrical testing. Stickers demonstrated that equipment had been serviced by the clinical engineering department or manufacturer. An electrical maintenance team was responsible for annual safety testing of equipment. The equipment we looked at all appeared in good condition.
- Equipment service records were kept on a database. If equipment was broken it was replaced from the equipment library or by a loan from the manufacturer pending replacement.

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- The obstetric high dependency unit (HDU) was located next to the anaesthetic office. It had four beds used for recovery or women needing a higher level of nursing care. Staff told us that on occasion women were recovered in delivery suite rooms, which all had outlets for suction, oxygen and air.
- Staffing levels meant that women could not always be cared for in line with the National Institute for Health and Clinical Excellence (NICE) guidelines requiring one to one care by properly trained staff until a woman had regained airway control and cardio-respiratory stability. Managers told us they were aware of the training gaps and had a training plan in place for staff.
- The postnatal ward (8F) had four four-bedded bays and 14 individual rooms. Three four bedded bays were identified as transitional care bays. The 13 single rooms were used for women with babies in the special care baby unit, neonatal intensive care unit, and vulnerable women and as amenity rooms.
- In our previous inspection we found that managing capacity in the delivery suite and postnatal ward was a challenge. The opening of the midwife led delivery unit (AMU) in November 2016 had increased capacity by freeing up rooms on the delivery suite. The AMU had four birth rooms, three side rooms and three triage rooms. The trust told us there had been no capacity issues since it opened. However, staff told us there were still on going capacity issues where the diversion of women to other hospitals in the trust were discussed.
- On our last inspection, we found checking procedures for emergency trolleys were not regularly completed. We reviewed records of three months before our inspection and saw that regular checks had taken place on resuscitation trolleys, neonatal resuscitation trolleys, the hypoglycaemia kit, sepsis trolley and haemorrhage kit.
- CTG equipment was available and had been safety tested. Fetal blood analyser and fetal heart rate monitoring equipment for high risk pregnancy monitoring was available and safety checked.
- Laboratory facilities and blood and blood products were available if required.

Medicines

- 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, stock levels were correct.
- Staff recorded allergies on the drug charts, alongside other risks such as a VTE risk assessment. Women wore wrist bands to indicate if they had any allergies.
- A named pharmacist visited the maternity unit daily. Stock arrived weekly and was topped up by a pharmacy technician when required. Wards had access to a pharmacist between 9am to 5pm, Monday to Friday. They were responsible for screening drug charts, medicines reconciliation, ordering and topping up of drugs from the main pharmacy, ordering 'to take out' (TTO) medicines for patients and advising staff.
- The Royal London Hospital site had a 24/7 pharmacy service. The on-site pharmacist provided on call services for all other Barts Health hospital sites when the hospital pharmacy was closed.
- An external pharmacy provided, via a service level agreement, an outpatient dispensing service at the Royal London Hospital.
- Resuscitation equipment was available for use in an emergency. Staff were allocated to check resuscitation equipment and we saw that checks were recorded.

Records

- At the previous CQC inspection we had concerns about the standard of record keeping. We saw there had been improvements in record keeping and adherence to The Nursing and Midwifery Council (NMC) rules on record keeping. Intensive training had taken place in January 2016 on documentation and record keeping, scrutiny of notes and role play for senior staff. There was an on-going record keeping audit. However, despite this training, we still found some gaps in records.
- Staff in the antenatal clinic told us folders for new sets of notes were held in the clinic. All these notes had pre-printed schedules of care and other locality specific information inserted, so that when women left their booking appointment, they would have the correct contact information. They also had a schedule of visits for their type of pregnancy, for example if this was their first child, if they were expecting more than one child or they had a medical condition such as diabetes. Four maternity support workers helped with records. Active notes were stored by the medical records department. Hospital notes were available for all bookings so that all relevant information from previous pregnancies and other aspects of women's medical history were available for review.

- We looked at three sets of notes on the delivery suite and saw they were legible, signed and dated. They recorded demographic data, multi-disciplinary care planning and appropriate documentation by medical team when they had reviewed women. Some women's antenatal notes did not record blood test results at booking, and there were inconsistencies in recording antenatal VTE assessment.
- We reviewed three sets of notes of both mothers and babies on the postnatal ward. Some loose sheets were evident so we could not be assured all information was in women's files. These notes were not all complete. One did not document the handover of care of mother and baby from the labour ward to the postnatal ward and birth summaries were not consistently completed, lacking baby details and swab count records.
- Records were not always stored securely. In triage, on level six, we saw six sets of notes unattended on the reception desk. Patients were sitting close by and all staff were busy in individual rooms caring for women. Patients' personal information was easily accessible and could potentially be viewed or removed by unauthorised people.
- The maternity unit's current IT infrastructure did not support good record keeping. Although clinical information such as scan results could be accessed through the computer system, some staff told us this was not easy to use.
- Staff often relied on the woman to communicate information about their pregnancy and care plans when they contacted the labour ward team. Community midwives could not access all women's test results remotely.
- At the previous inspections in 2015 and 2016 we were told funding had been secured to move to an electronic system to capture patient information during childbirth and in the postnatal period, including CTGs, partograms, all labour events and outcome information in real time to improve patient care and reduce human error. At the time of this inspection it was not in place.
- The trust had an electronic patient record system. The system flagged patients at risk of falls and any with MRSA or CDiff. The system also provided an alert for patients with learning disabilities or dementia. The system required password access to ensure security. Staff members each had individual accounts to ensure professional accountability.
- Data protection was part of the staff mandatory training programme.

Safeguarding

- The chief nurse of the hospital was the executive lead for safeguarding children and adults. In maternity services this role was devolved to the director of nursing for babies, children and young people. For safeguarding children there was a lead named nurse for safeguarding children at a corporate level and a named nurse for safeguarding children and safeguarding children advisors on site. 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.
- All permanent staff providing direct care to pregnant women had access to safeguarding adults and safeguarding children training. Most of the staff we spoke with understood their responsibilities and were aware of trust safeguarding policies and procedures. However, safeguarding adults (SA) level 2 training levels were below the trust target of 90% in almost every department.
- SA level 2 training rates varied with only 55% of midwives on the postnatal ward , 57% on the midwifery led unit, 57% of community midwives and 76% midwives on wards 6E, F and 8E having completed training.
- Safeguarding children level 2 training was slightly below the trust target of 90%. Compliance rates were between 85 and 87% on wards 6E, 6F, 8E and postnatal ward and 85% for community midwives. All midwives on the midwifery led unit had completed training.
- Rates were below target for safeguarding children level 3 training with 75% of staff on the postnatal ward and 8E midwives, 77% of community midwives and 85% of ward 6E and 6F midwives trained to level 3**.** All midwives on the midwifery led unit had completed level 3 safeguarding children**.**
- 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. Midwives and medical staff were required to attend level

3 safeguarding children updates in line with the intercollegiate document 2015. The service was not meeting this standard. The trust was aware it was not meeting its target for training; however it was unclear what plans were in place to improve training rates. Staff told us booked training was often cancelled by managers as they were needed at short notice because they were short staffed on the units.

- There was a well-established dedicated team of specialist community midwives for supporting mothers at risk. The gateway team offered midwifery care to women with complex social needs. This included young mothers, mothers at risk of domestic abuse, female genital mutilation (FGM), severe and enduring mental health illness, substance misuse, child protection concerns, women with learning disabilities, asylum seekers and refugees.
- Midwives followed multi agency statutory guidelines on women with FGM with women at risk allocated a midwife. A midwife with lead responsibility for safeguarding was always on-call at weekends.
- The trust had guidelines in place for safeguarding vulnerable women and reducing harm to the mother, the unborn or new-born baby, and any other children in the family.
- Midwives said they were pro-active in following up women who may have booked late in pregnancy or missed appointments and could arrange follow up when women did not attend an appointment. Midwives reported excellent support from site based social workers, but lacked administrative support. They considered that such support would increase their effectiveness.
- Midwives were aware of the policy to ensure they asked women about mental health, including depression and anxiety, at booking. However, some of the midwives we spoke with were less assured that all women were asked about their mental health at later stages of pregnancy. There were clear guidelines for acceptance of women referred to the mental health pathway which offered psychological support for women with perinatal/ postnatal mental health.

Security in maternity

- At the last inspection CQC required urgent improvements to security arrangements in the maternity service. During this inspection we found some improvements in this area, for example, there had been a reduction in unsecured entry and exit points on the wards. Access to most areas of the maternity and gynaecology wards was now restricted by use of swipe cards. When we were taken around the unit, we were told there were still some unlocked entrances; however, work was being carried out to address this.
- At the last inspection, baby identification was also identified as a risk because staff were not routinely checking babies' identification labels. They were not always checking babies' name bands on the postnatal ward to ensure babies were paired with the right mothers, and to ensure the right baby received the right medicines. Staff on the postnatal ward had also been unaware of the trust policy on patient identification which included babies.
- On this unannounced inspection the majority of staff were aware and clear on what they were required to do for baby identification. We saw twice daily checks were made and where name bands missing, either because they had become loose or been removed by parents, records showed they had been replaced. Baby identification was recorded on the service risk register as a 'medium' rated risk across all of the trust's hospitals and guidelines were in place for staff to follow in the event that a baby was found to have no ID label. The manager told us it would be reported as an incident which was confirmed by staff.
- At the previous inspection in July 2016 we were told that a business case for baby tagging had been approved and would be implemented by autumn 2016. However, we found in September 2016 electronic tagging had been deferred until the next financial year. Funding had now been agreed and we were advised by the trust that it would be installed by the end of August 2017.
- Entrances in all the areas where babies were cared for were entered via secure locked doors with intercom communication. If locked, these doors could only be opened by an internal mechanism or by a swipe card system on the outside. However, doors could be opened on the inside by anyone wanting to leave the area and the area was not always monitored. The hospital was in the process of implementing recommendations to tag babies however this was not yet in place. This meant there was a possibility that staff, patients and visitors could leave the ward with a baby and they would not be alerted. Staff raised this with us as a concern as they felt it was a risk.

- Since the last inspection the hospital had put in place measures to mitigate risks to baby security including increasing reception staff cover. Staff told us that whenever possible 24 hour reception cover was provided on the postnatal ward. However, there was not always a receptionist available and there were no arrangements to cover breaks. Reception staff asked visitors who they had come to visit, so they could check if the woman was an inpatient, how many visitors she had already and whether a woman had any restrictions on her visitors, for example for safeguarding reasons. When there was no receptionist, midwives had to admit visitors as well as caring for mothers and babies, which presented risks in ensuring effective control over visitor access.
- On level 8 there was a secure electronic door release system to the reception area outside the postnatal ward via a buzzer, with a small screen for the receptionist to see who was coming in. However the door to the postnatal ward was not locked. Managers had told us entrance doors to wards were always locked. However, on the morning of the unannounced inspection we were able to walk straight into the level 6 delivery unit, as there was no one present in reception and doors to the unit were unlocked. We were not challenged on the delivery unit as all midwives were in individual patient's rooms looking after patients and were not aware we were there. When we visited later in the day reception staff were present and checked who people were.
- The level 6 reception area was not always covered by staff overnight. Staff told us the main door was left unlocked overnight to allow women to get onto the delivery suite as staff were often busy and would not hear the call bell.
- Reception staff could view via CCTV who was entering reception area. Managers said the layout of the post-natal and delivery suite wards had multiple entrances and exits and the current systems meant not all doors could be locked. Work was already in progress to improve security by reducing the number of entrances and exits to the units. We alerted staff in the hospital of the security issues we found and measures were put in place to ensure doors were kept locked and security improved.
- The hospital had introduced a pass system to reduce the number of visitors on the postnatal ward. This had been introduced to help manage the number of visitors on the post natal ward, by allowing staff to track the number of visitors at each bedside. This also helped mitigate security issues about baby security raised at the last inspection. The visiting policy had been reviewed and local protocols put in place for staff to follow. Only three visitors were allowed in for each patient at any one time and provided with lanyards with passes, red for visitors and black for the partner, which they were required to wear. We were given a number of examples where this had not been adhered to. For example, the week before our inspection staff had found over double the amount of visitors around the bed of one patient. This had only been noticed because of the noise coming from the area. Staff told us this happened on a weekly basis but was much less frequent with the introduction of the pass system.
- The postnatal ward was a busy ward with patients, visitors, other professionals and maintenance staff frequently coming and going. We saw that visitors did not always wear the passes provided, and were not challenged by staff. We asked one visitor we had seen leave and return to the ward where their pass was, they told us it was in their back pocket.
- Reception staff when present were proactive and ensured all visitors were asked who they had come to visit when they arrived.
- Staff told us there were still issues with patients letting in more visitors than they should have although this had reduced. Women and their partners were informed of the ward baby security arrangements and were required to consent and sign a form to say they understood their role in ensuring babies should have two name labels on at all times.
- We saw reception staff sometimes had to leave reception unattended at various times and go into the ward. We observed on one occasion the entrance to postnatal ward was left open for 10 minutes, including when there was no receptionist present which meant anyone could go in without being noticed.
- Staff told us visitors sometimes went home with passes and they relied on patients relatives to return them. Managers we spoke with suggested the system worked well; however this was not based on any audit on how the system worked. Staff said the system had been effective in reducing the numbers of visitors for each patient at any one time.
- Information was not available on how often visitor passes were not returned as no records were kept of

who they were issued to. Staff told us there was no process in place or record of how often passes were taken home or not returned at the end of the day as these were not reported as incidents.

- On the previous inspection we had observed there was no security guard present at visiting times to support enforcement of the visitor policy. Visiting times were not consistently enforced by staff, including the end of visiting time. Staff described getting visitors to leave as a "game of cat and mouse". Staff told us visitors often phoned friends already on the ward to let them in. Managers explained they had implemented additional security guard presence earlier in the year, however this had not worked. We were told this had been reviewed and regular walk-arounds during the day and night were implemented, and we observed this on the day of the inspection.
- Trust policy was for staff to ensure they kept their own trust ID badge and computer pass secure. We found one staff ID badge on the desk of the treatment room on the postnatal ward. The room was not locked and door was open with visitors and external maintenance staff passing and could easily have been removed. The computer was also unlocked with pass in place enabling unauthorised people access to patient personally identifiable information.
- We informed the lead nurse who told us they had a similar situation recently where the pass had been taken from the ward and had not been found. Staff had been reminded of the responsibilities at that time verbally in a team meeting. We were told this would be reported as an incident.
- We reviewed the trust infant abduction policy dated 19 March 2015. This assumed electronic baby tagging was in place, which it was not at the time of our inspection. The trust informed us this was to be installed with plans to go live in September 2017.
- The infant abduction policy stated it should be tested either as a desktop exercise or in practice. However, staff told us these sessions had not taken place although all staff were aware of what they should do.

Mandatory training

- Mandatory training was delivered as a combination of e-learning modules and practical teaching sessions. Staff received reminders when training was due and could book online. The mandatory and statutory training programme included equality and diversity, health and safety, basic life support, infection control, information governance, adult and child safeguarding, fire safety, manual handling and conflict resolution.
- The service was not meeting the 90% target for mandatory training in some areas, including basic life support and infection control and prevention. Only 60% of staff on the postnatal ward, 78% of ward 6E and F, and 66% of ward 8E nursing and midwifery staff had completed infection control training.
- The trust's corporate resuscitation policy was dated 2012 and had not been reviewed since. It referred to resuscitation council 2010 standards and not the most recent 2015 current standards.
- There was mandatory multi-professional team training for CTG assessment, and 'skills and drills' to rehearse obstetric emergencies. Every member of staff in the maternity service was given a copy of the Practical Obstetric Multi-Professional Training (PROMPT) manual.
- Staff were required to attend mandatory training in obstetric emergencies and PROMPT training was provided for multidisciplinary groups which included consultants, staff grade doctors, doctors in training and all grades of midwives. The training included classroom sessions and simulations of events. Clinical staff told us they had regular skills and drills training for managing obstetric emergencies.

Assessing and responding to patient risk

- During the last inspection in September 2016 we highlighted that the Safer Childbirth London Safety Standards and the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations had identified the risks to women's care associated with being unable to provide a 24 hour consultant presence on the labour ward. Since then the hospital had increased its consultant presence by 20 hours, however, the service had not met its own target to ensure the provision of 98 hours per week consultant presence on the labour ward. The service averaged 83 hours between November 2016 and April 2017.
- At the antenatal booking appointment women had a full assessment of physical, social and mental health needs completed. They were then allocated either consultant or midwife-led care, depending on their needs. This ensured women with risk factors were seen by appropriately trained professionals.

- Midwives were involved in the triage process. A woman could telephone or attend the antenatal assessment unit or labour ward to be assessed and triaged by any of the midwives on duty. We reviewed the trust's policy on maternity triage, which had clear guidelines on the criteria for admission and treatment of women to the maternity unit. The policy was evidence based and referenced Royal College of Obstetricians and Gynaecologists (RCOG) guidelines regarding preterm premature rupture of membranes (PPROM), fetal movement and fetal monitoring guidelines. Staff told us that if they were unsure of their assessment they felt confident in seeking advice from more senior colleagues. The fetal growth assessment protocol (GAP) was introduced in October 2015 to help identify babies who were not growing as well as expected.
- There was bespoke documentation for staff to monitor the health of patients, which included criteria for escalation. We looked at three records of women in the delivery suite and found the documentation was appropriately completed.
- Midwives conducted risk assessments for women at their initial appointment. This included indicators such as raised body mass index, height to weight ratio, diabetes and pre-eclampsia. There were systems to identify women with complex social needs including liaison with adult social services to address the needs of women with learning disabilities.
- We found evidence of good compliance with the surgical safety checklist in obstetrics and gynaecology procedures. Risks for women undergoing obstetric surgery were reduced as staff followed the five steps of the World Health Organization (WHO) surgical safety checklist. Staff in theatres completed safety checks before, during and after surgery. Checks were recorded on the patient electronic patient record. We saw an audit on compliance with the surgical safety checklist and reviewed three records for women who had a caesarean section, which showed that the checks were completed appropriately.
- Staff had access to emergency trolleys in the event of an obstetric emergency. These were easily accessible in corridors.
- A screening coordinator was responsible for antenatal and new born screening. At the previous inspection the service dashboard indicated a high risk rating in relation to meeting the standard of achieving sickle cell and thalassaemia screening by 10 weeks of pregnancy. If screening was positive, partner screening was offered and subsequent diagnostic testing offered if both parents were positive. On this inspection we found the service was able to demonstrate that women had access to this screening, but it was still not meeting the standard within the required timeframe in all cases.
- Midwifery staff completed observations on patients and babies and recorded these on neonatal early warning score (NEWS) charts and modified early warning scores (MEOWS) charts. At the previous inspection we found modified early warning score (MEOWS) charts to monitor women in labour and detect the unwell or deteriorating patient, were not always completed. In a 2015 audit only 75% of charts had shown MEOWS calculations, and for only 34% of women were there clear instructions on frequency of observations. A re-audit in May 2016 reported much improved results and made several recommendations, including redesign of the chart. The service had made some progress on the recommendations and was halfway through training programme for midwives. Staff told us they were confident MEOWS were being completed correctly. Four MEOWS charts we looked at in the delivery suite were appropriately completed.
- A daily safety huddle had been introduced on the delivery suite including staff from the postnatal ward, the antenatal clinic and the community. The purpose was to identify any staffing, operational or capacity issues. We were told that if, for example, the postnatal ward was full, joint discussions would take place between paediatricians, obstetricians and midwifery staff to identify any women who could be discharged more quickly. However, we did not see local follow up action taking place after the huddle we attended.
- A hospital-wide nursing safety huddle was held each day at 9.30am. This was attended by representatives from all areas of the hospital, including midwives. It was an opportunity for the senior management team to get an overview of staffing and capacity issues as well as clinical alerts such as infections, pressure ulcers and recent clinical incidents.
- At the previous inspection we had been told about the introduction of a short safety briefing at handover to mitigate risk. Previously the proforma completed at the safety huddle showed this briefing had only happened on 12 out of 28 days. On this inspection we looked at how often the safety briefing was being completed as it should be a daily occurrence. We found only 12 out of 30

days in April 2017 and 13 out of 31 days in May 2017 had safety briefs completed. Audits undertaken by the service identified this as work in progress and not yet fully embedded. On this inspection a safety briefing did not take place on the postnatal ward on the day we observed handover.

- One room on the postnatal ward was designated as a baby discharge clinic. All babies were offered a hearing check before leaving the ward. Records showed 98% of babies had been screened within the previous four weeks before our inspection.
- Venous thromboembolism (VTE) assessments were audited on a monthly basis. The service had not met its target of 100% for five of the six months between November 2016 and April 2017. Results from April showed 93.6% of women were having their risk of blood clots assessed. However, the scoring system for VTE on the trust's computer system was different to that on the new VTE stickers in the high dependency unit (HDU) and different to RCOG guidelines, which meant different assessment standards were being used by different clinicians.

Midwifery staffing

- At the previous inspection, midwifery staffing had been graded as high risk on the service risk register. An increase in permanent staffing and use of bank and agency staff to fill staffing gaps had reduced this risk to moderate. Staff confirmed the increase in staff numbers and increased use of bank staff had reduced pressures and made the workload more manageable. Staff and managers told us the implementation of workforce retention strategies and an increased use of bank staffing meant they felt less pressured and had an improved work life balance.
- The funded midwife to woman ratio at the hospital had been increased to 1 midwife per 28 patients (the national average), from a ratio of 1:31. However, staff told us that due to ongoing vacancies, the number of midwives working clinically was in practice well below this. Bank and agency staff were frequently used to help cover the gaps.
- Between June 2016 and May 2017 over one third of staff working in some areas were either midwifery bank or agency, averaging 35% per month across maternity services.
- Many staff raised concerns about the skill mix of staff on shifts. Specifically, that there were not enough experienced midwives to supervise and support less experienced staff and manage the level of complexity and acuity of women on the postnatal and labour wards. Managers told us there had been a reduction in the number of vacancies form 32 to 19. These were were shared out amongst all clinical areas.
- Newly qualified midwives were required to rotate during the period of their preceptorship programme. There was a comprehensive preceptorship programme for newly qualified midwives.
- Some staff continued to raise concerns that ward coordinators were not supernumerary, which impacted on their ability to effectively oversee and coordinate the clinical area. Midwives expressed concern that the absence of a supernumerary coordinator would potentially be a higher risk when newly qualified midwives started in the autumn, as they would not have adequate training and support. Best practice was to have an experienced supernumerary delivery suite coordinator to oversee safety on the labour wards, to support clinical staff and to manage workload and activity. Managers told us where staffing levels permitted, they tried to ensure coordinators were supernumerary. However, this was often not possible. Funding for an additional 2.6 whole time equivalent midwives had been agreed. One member of staff was already in post with another expected to start in July 2017.
- Although staff strove to achieve 1:1 care in labour, midwives said this was not always possible. The maternity dashboard showed 95.2% of women had one to one care in 2016/17 and 96.4% year-to-date for 2017/18. When midwives were busy with women giving birth, those awaiting triage, having inductions, or mothers still on the delivery suite after giving birth, women could wait a long time for care or assessment.
- Staff in the high dependency unit (HDU) worked 12 hours shifts of 8am to 8pm (day shift) or 8pm to 8am (night shift). Two HDU staff were rostered to work each shift. This tended to be one registered nurse and one midwife. There were two health care assistants (HCAs) on the delivery suite, one of whom accompanied emergency cases to theatre.
- Triage was supposed to have two midwives per shift. Staff told us this was not always possible and staff were moved from other areas to cover if available. They felt staffing levels could be unsafe at times due to the high volume of patients and the number of high risk patients.

Staff on wards also raised the same concerns. Staff commented that flow was a challenge and they had problems retaining staff. Between June and May 2017 the staff turnover rate was 20% which was higher than the trust's target rate of 14%.

- The postnatal ward staffing was four midwives and three HCAs by day and three midwives and three HCA at night. Band 4 nursery nurses assisted midwives in the care of transitional care babies. Staff said they were regularly moved to other areas to cover shortfalls so there was frequently fewer staff on the ward than the required establishment which led to delays in care and transfers to the postnatal ward could be delayed because there was no one to accept them. Staff were supposed to complete incident forms when this happened but several staff said they often did not have time to do this.
- Midwives were able to rotate through booking clinics, fetal medicine and the DAU so that there was variety in their role.
- Midwives said they could access medical staff relatively easily and consultants were approachable and happy to help.
- There were a number of specialist midwives, for example, for postnatal, antenatal and new-born screening. There was also a clinical practice facilitator, a practice development midwife and an audit midwife. A clinical educator midwife supported the preceptor midwives.
- The maternity service was supported by one band five physiotherapist working 8.30am – 4.45pm Monday to Friday.
- In previous inspections we identified sickness management and staff lateness as areas of concern, but during this inspection we found this was being addressed. Sickness rates for nursing and midwifery staff averaged 3.9% over the three months prior to our inspection. However, we observed several staff arrived late on the morning of our inspection.

Medical staffing

Obstetric staffing:

- At the previous inspection we reported concerns about the level of consultant cover on the delivery suite. The maternity risk register highlighted lack of obstetric consultant presence as high risk. At the time, the level of cover was on average 71 hours per week up to August 2016. Trust data demonstrated that this had increased to 83 hours per week between December 2016 and June 2017. The trust told us they were recruiting two locum consultant obstetricians to increase consultant cover to 98 hours per week and provide onsite cover from 8am-10pm, seven days per week. The new consultants were due to start in post in August 2017.
- The current 83 hours of resident consultant cover for obstetrics and gynaecology was available from 8am to 10pm Monday to Friday, with cover on Saturday and Sunday commencing at 8am and continuing until 2pm or 10pm depending on the individual consultant's job plan. Three consultants covered maternity only, with a separate gynaecology on-call consultant available if required.
- From Monday to Thursday, out of hours consultant offsite cover was provided between 10pm-8am.
- The weekend on-call consultant on Saturdays and Sundays joined the morning handover on both days, and was resident for varying numbers of hours according to their individual job plan. They were then available offsite for the remainder of the weekend.
- Consultants were supported by two senior doctors in training and two junior doctors in training per shift (one of each for both obstetrics and gynaecology), plus an obstetric anaesthesia doctor in training, for 24 hours per day, 7 days per week. Doctors in training worked 12 hour shifts from 8am – 8pm.
- Obstetric anaesthetic consultants provided anaesthetic cover from 8am until 6pm Monday to Friday, and outside these hours the doctor in training could seek support from a consultant anaesthetist covering the acute adult services in the hospital. Anaesthetic cover met Safer Childbirth (RCOG 2007) recommendations. At night cover was from a training grade anaesthetist specific to obstetrics, with support, as needed from hospital anaesthetists and consultant on call.
- There was a separate obstetrician, assistant and anaesthetic theatre team for the elective caesarean section list which was normally run on three days per week. Additional operating lists could be organised on Mondays and/or Fridays if there was demand.
- An anaesthetist did a ward round of the HDU three times per day and an obstetrician visited as necessary. In addition a consultant obstetrician visited patients twice a day as part of an MDT ward round. The anaesthetists said they had good working relationships with obstetricians.

- Doctors in training reported having a full induction over three days which included simulation training. They had a weekly CTG training session supported by an e-learning package. Rota gaps due to sickness were filled by locum doctors or by research fellows. Doctors in training told us they felt well supported by consultants and reported good access to supervision, teaching and advice. One said the hospital had a good reputation for supporting doctors in training and consultants reported positive feedback from doctors in training and locum doctors.
- Handover on the delivery suite involved midwives, doctors and anaesthetists. There was consultant input. We did not observe staff applying a structured tool such as situation, background, assessment and recommendation (SBAR) technique to communicate key information effectively and efficiently, which meant the handovers we observed were longer than necessary. Care management plans were not agreed in the handover we observed and the meeting was disrupted by late arrivals and early leavers. There was no obvious learning shared at the morning handover we attended.

Theatre staff:

- Obstetric theatres were staffed by the hospital's main theatre department. A paediatric theatre adjacent to the obstetric theatres could be used as a third obstetric theatre in an emergency.
- Sonographers were managed by the radiology team and services. Two midwife sonographers had been trained to work with the fetal medicine team.

Major incident awareness and training

- The trust had an incident response plan. This was a trust-wide document and there was a separate 'Maternity Escalation, Unit Closure and Business Continuity Plan' document. This provided 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 in the document. The plan included emergency contact numbers for staff and business continuity plans ensured the service was maintained. An escalation policy was followed to suspend activity or close the maternity unit in the event of staff shortages, postnatal bed shortages or a full labour ward. This could also be used in extreme situations such as infection outbreak in the maternity unit, or fire. There were protocols for deferring elective activity to prioritise unscheduled emergency procedures. Shortly before our inspection a failure of the trust's computer systems had triggered the major incident plan.
- All staff had access to annual fire safety training. Nurses we spoke with were able to clearly explain the evacuation procedure for the 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 also taken place at regular intervals.

Are maternity and gynaecology services effective?

Good

We rated effective as good for effective because:

- There was a systematic programme to review and update clinical guidelines in line with recommended standards.
- Midwives were supported to maintain their competencies and consultant midwives supervised staff professional development. Staff knew how to access professional guidance.
- Outcomes for women and their babies in the maternity service were within expected national parameters.
- Women could choose where to receive antenatal and postnatal care, either in the community or at antenatal appointments at the hospital, where appropriate.
- The maternity service collected data on how it performed against national indicators. There was a monthly dashboard so managers knew how the unit was performing against service targets. However, this was not shared with all staff.

However:

- Although the maternity service collected and monitored outcome and performance data, there were some inconsistencies and gaps in data collection.
- There were some inconsistencies of practice where trust protocols had changed but were not being adopted by

all staff, for example, in enhanced recovery for women with planned caesarean sections, and changes in VTE assessment which led to different algorithms being used by doctors and midwives.
- Only 95.2% of women received one to one care in labour against a target of 100%. Few women had continuity of midwifery care with the same named midwife.

Evidence-based care and treatment

- At the previous inspection we found the service was following most aspects of the London Quality Standards for maternity, which was consistent with effective national practice.
- The hospital's obstetricians played an active role the North East London network for benchmarking and peer review.
- We saw evidence of regular audits of procedures and practice, the findings of which were disseminated with actions identified. There were monthly audit meetings in maternity services. Information from audits was emailed to managers and medical staff. It was then the responsibility of managers to disseminate information to their teams.
- Trust policies were based on national guidance produced by NICE and the RCOG.
- At the last inspection the local Clinical Academic Group (CAG) had set up a maternity guidelines group to oversee the updating of the maternity guidelines trust-wide, including reviewing compliance with NICE guidelines. Women being treated at the hospital were receiving care in line with the NICE guidelines and quality standards.
- The hospital had met the National Screening Committee (NSC) recommendations for 90% of women to attend their initial antenatal appointment set at 12 weeks and 6 days. Some staff told us the new NSC performance target for women to be booked by 10 weeks gestation would be a challenge as women in demographic groups within their catchment area often did not attend their appointments early enough.
- At the last inspection guidelines for intrapartum care had been introduced with publicity and training for staff. Staff had carried out a baseline audit of monitoring in labour as services had not been audited since 2014. However, at that time we saw from patient notes that midwives were not routinely using the well-established 'fresh eyes' system where a senior midwife would review the CTG recording of a baby's heart rate, or doing this through a buddy system. At this inspection staff told us the 'fresh eyes' system had been introduced in May 2017 but was not yet embedded. All maternity staff were given a booklet on 'fresh eyes' and it was the responsibility of the midwife caring for women to complete.
- The service participated in national audits. For example, they contributed HDU admissions information to the Intensive Care National Audit and Research Centre (ICNARC). They also carried out benchmarking with other maternity units in the trust, and external hospitals, comparing post-anaesthetic data with results from another London hospital.
- The service submitted data to the RCOG Each Baby Counts project, bringing together investigations into stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour. The service contributed data to the National Neonatal Audit Programme (NNAP) and to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK), as well as measuring key performance indicators required by commissioners, such as screening and unborn safeguarding.
- There was a programme of local clinical audits for 2016/17 and these were used to monitor improvement. Since our last inspection the hospital's quality report in December 2016 highlighted a re-audit of practices in the delivery suite showed notable improvements. In the earlier audit, 30% of case-notes reviewed had documented swab count pre and post-delivery, this had risen to 93% in December 2016. Results of audits were communicated through a newsletter and in safety briefings.
- The service had not adopted the nationally recommended CTG stickers (2014) to monitor the fetal heart rate in labour. Instead, staff used NICE guidance from 2007, which was still used by many other London hospitals. Obstetricians told us this was part of a strategy to await universal agreement on optimal recommendations.
- At the previous inspection we found many women who had been in the obstetric theatre were taken to the postnatal ward after half an hour. This was not in line with trust policy on recovery which recommended women should stay for four hours in recovery. However, we saw that staff followed the trust's post-operative protocol on frequency of observations for women when they transferred to the postnatal ward.

- Obstetric anaesthetists monitored their outcomes and had recently produced a dashboard for key indicators capturing outcomes for labour analgesia, anaesthesia for caesarean sections and complications such as multiple attempts at needle insertion, intraoperative pain and accidental dural tap (when the epidural needle accidentally broaches the dura and a leak of cerebrospinal fluid occurs which causes severe headache). This monitoring tool had enabled staff to monitor complications and identify training needs.
- The hospital and community midwifery team worked proactively to support women to breastfeed and provided continuing support to women at home. The trust had appointed an infant feeding coordinator to introduce sessions for new mothers and improve monitoring of breastfeeding. However, staff told us that when they were not there it was sometimes difficult to find the time to continue sessions as patient care took priority. The percentage of women breastfeeding remained high. Women told us they were encouraged to breastfeed and help was available on the ward. Trust data showed 83% of women were breastfeeding post-delivery, and 86% on discharge from hospital.
- The maternity service had achieved full accreditation level 3 of the UNICEF UK Baby Friendly Initiative to promote good care for new born babies.
- Across the trust sites there were various maternity research projects. An example of this included a randomised controlled trial on giving progesterone for bleeding before 12 weeks in pregnancy and pre-eclampsia. The unit was also involved in research led by others, for example an evaluation of non-invasive prenatal testing (NIPT) for Down's syndrome, and a patient reported survey and assessment of mothers oral health, looking at possible association between gum disease and premature birth.

Pain relief

- Most women we spoke with told us their pain had been well managed. However, some women told us they had waited a long time for pain relief because the wards were very busy. One woman told us "I was in a lot of pain after my caesarean and asked for stronger painkillers but was never offered anything else**".**
- Women's pain relief options during labour included epidural analgesia, opiates, nitrous oxide (gas and air), and paracetamol. A ready to use medical gas that provides short term pain relief was available in all the birth rooms.
- Care records we reviewed contained information about women's pain relief.
- Midwives told us an anaesthetist was always available on the delivery suite. However, we saw women on the low risk area of the delivery suite could have long waits after requesting an epidural because of the policy to move such women to the high risk area. Midwives were often too busy to do this.
- Epidural response times collected by the service were variable. The trust target was for 80% of women to be treated within 30 minutes and 90% within one hour. This target was met for three of the six months between January and June 2017. However, the target does not follow the recommendations from RCOG for all women to receive treatment within recommended timeframe. We saw from the epidural surveillance sheet that women could wait six hours for an epidural. Safer childbirth recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 states that they should be able to receive it within a reasonable time, not normally exceeding 30 minutes and must be within one hour, except in exceptional circumstances.

Nutrition and hydration

- Women we spoke with told us that the food and drink provided to them was adequate and snacks were available outside meal times. We spoke with two women on the postnatal ward who told us the food was adequate and that the service had catered for their special dietary requests. However, some women told us they did not like the food and we saw many partners bringing in food.
- The hospital had achieved 89% in the May 2016 patient led assessment care environment (PLACE) survey. This was an increase of six points from the 2015 survey of 83%.

Patient outcomes

Maternity and gynaecology

- At the last inspection we reported concerns about the availability of hospital data to effectively monitor patient outcomes. On this inspection we observed some improvements. However, there were still significant gaps in data collected by the trust.
- Information was collected about the outcomes of women's care and treatment and performance monitored using a maternity dashboard. This was a clinical governance tool for monitoring of a range of clinical indicators to enable quality and safety assurance monitoring, as recommended by RCOG 'Good Practice number 7'. Information was shared externally with stakeholders and within clinical networks, and internally for the service and the trust board.
- We reviewed the dashboard for the period May 2016 to May 2017. The main challenges reported on the dashboard were in achieving recommended staffing levels, both consultant and midwifery, and booking women before 12 weeks 6 days gestation.
- Between April 2016 and March 2017 there were 5,115 births in the hospital with 8% delivered in the midwifery-led unit and 92% in the obstetric-led unit.
- The total percentage of patients that required a caesarean section was over 30% which was worse than the annual national average of 25% over a twelve month period. Senior leaders of the service were aware there was a higher than average number of caesarean sections and there was an action plan in place to review processes. Service leaders identified they had higher than average percentage of women with complex needs, which may account for the high prevalence of caesarean section deliveries. The percentage of elective caesarean section rates for the six month period before our inspection was above the 10% target for four of the six months.
- Trust audits identified that 41% of emergency caesareans were not carried out within standard time limits, and the reasons for this were given as 'other'. The audit documentation did not make it clear why there were delays.
- Between April 2016 and May 2017, 14% of births were instrumental deliveries, which was higher than the trust target of 10%
- Since our previous inspection the maternity unit had increasing numbers of women referred for ante-natal care. In the six months between November 2016 and May 2017, 4,132 women had registered for ante-natal care.
- In 2016 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) rated the Royal London Hospital maternity service as 'green' using risk adjusted methodology in perinatal mortality reports from 2014 and 2015. There were 47 stillbirths over a 12 month period covering 2016 to 2017. The still birth rate was 10% lower than similar hospitals (other units with a Level 3 NICU and a neonatal surgical unit).
- One to one care in established labour had averaged 95.2%, lower than the NICE standard of 100%. Some staff on the delivery suite told us they could only achieve one to one care if they did not take breaks.
- In 2015/16 there were 295 unexpected admissions to NICU, representing 6% of all women treated by the service. Trust data recorded the main cause of unplanned admission as respiratory distress, as well as other factors including sepsis.
- The percentage of babies born at the hospital with low or very low birth weight was 12%, just above the England average of 10%. 12% of babies were delivered at the hospital with a gestation of less than 37 weeks.
- The percentage of inductions of labour was 20.8% for 2016/17, better than the England average of 26.5%.
- The home birth rate was low – only 0.97% (50) women gave birth at home between April 2015 and March 2016. The national average was 2.3%
- The postpartum haemorrhage rate was low with 3% of women experiencing blood loss over 1500ml.
- 27% of births were classed as 'normal' unassisted births which was lower than the London average of 40%.
- The percentage of vaginal deliveries was 61% which was slightly below the service target of 65%, although the RCOG recommendation was 70%.
- The unit carried out amniocentesis and chorionic villus biopsies (tests performed during pregnancy to determine if an unborn child was at risk of a congenital defect). All women registered with the hospital were offered free fetal DNA testing when they took part in screening. This test results were available within three working days. There was a high background rate of fetal abnormalities because of high consanguinity rates in the local population. There was also a higher incidence of pre-term delivery and mid-trimester loss. We were told that women and their families rarely chose termination for abnormalities for cultural and religious reasons. There were 28 terminations for abnormality in the year to April 2016.

Maternity and gynaecology

- The unit undertook 124 diagnostic procedures in 2016/17 and had a loss rate of less than 1:1000 which was consistent with results elsewhere in the UK.
- A protocol was in place for community midwives to manage low risk women with diabetes in local antenatal clinics. The application of this protocol had been audited as successful. Haemorrhage and hypertensive disorders were the main indications for HDU admission (in line with MBRRACE reports).
- Staff in the service encouraged women to have a vaginal birth after caesarean (VBAC). The service aimed for 72-76% women who were on the VBAC pathway to achieve normal birth in line with the RCOG standard.
- The unit provided care to women across the trust with placenta accreta (a serious pregnancy complication), which was facilitated by the availability of 24 hour interventional radiology and expertise at the hospital.

Competent staff

- A midwifery education team worked across all of the trust's sites. However, the practice development midwifery team did not have administrative support until recently which had led to difficulties in maintaining an accurate database of staff training. A clinical educator had been employed to support recently recruited midwives to the hospital. The education team had a rolling system for identifying skills gaps and putting in place development opportunities for midwifery staff.
- Some staff said it was difficult to fit in training around their workloads, and that training was sometimes cancelled at short notice. Some staff told us staffing shortages led to midwives being taken off training to provide ward cover. Staff also told us the electronic rostering system meant they could not easily fit in training unless it was booked well in advance.
- Newly appointed midwives had a two week orientation period and newly qualified midwives followed a nine month competency based preceptorship programme to develop their skills.
- The hospital target for annual staff appraisal completion was 100%. Between April 2016 and May 2017, 87% of obstetrics and gynaecological staff, including 93% of midwives and 99% of gynaecological nurses had received an appraisal.
- In April 2016 the hospital introduced a 'sign up to safety' programme to reduce litigation and improve knowledge and escalation for concerns in labour related to CTG. This included a new training package on intrapartum fetal monitoring including intermittent auscultation (a systematic method of listening to fetal heart tones with an acoustical device to monitor heart rate) and CTG monitoring. The purpose was to improve multidisciplinary competency in fetal monitoring in labour and reduce stillbirth and intrapartum asphyxia (brain injury caused by oxygen deprivation).
- Anaesthetists provided a maternal critical care simulation course for midwives working in HDU. There was also a monthly in-service study day on recovery skills, although this was not externally accredited training.
- Doctors in training reported having daily training on wards and they spoke highly of their training and support they received from the obstetrics and gynaecology team. They said consultants were approachable and always willing to give advice. The doctors reported they also took part regularly in 'skills and drills' for obstetric emergencies.
- There was a programme for retesting clinical skills. 83% of the midwives who attended the first phase of the clinical assessments were retested. Findings from the programme identified had been a clear improvement on CTG assessment and clinical skills, together with decision making and appropriateness in plans of care.
- Midwives were encouraged to present interesting cases at case reviews to spread learning. Staff could also attend audit meetings but told us they generally did not have time to attend these because of clinical activity.

Multidisciplinary working

- There was an effective multidisciplinary team working environment and evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- All staff we spoke with reported good working relationships and told us different clinical groups worked well together as a team.
- We saw women's records which confirmed staff communicated with GPs and the community maternity team during ante-natal care and discharge.
- There was good communication with and support from specialists elsewhere in the hospital where women had medical conditions that might impact on their pregnancy. For example, a joint obstetric cardiac clinic

had been set up. This was open to women in other hospitals in the trust and there was a desire to increase the number of referrals so that RLH became the expert centre.
- Nurses had access to support and advice from other allied health professionals, for example dieticians.
- Obstetric anaesthetists reported effective working with theatre staff, midwives and obstetricians in theatre as a functional multidisciplinary team.
- Multidisciplinary team (MDT) clinics involving an anaesthetist, obstetrician and dietitian were held for clinicians to discuss care plans for 'higher risk' women, for example those with a high body mass index. There were also dedicated clinics for 'high risk' women. Anaesthetists took part in clinics for women planning a caesarean. There was multidisciplinary obstetric team training including on interpretation of CTG traces.
- There was evidence of cross-site MDT working across the trust through the perinatal network, which was a multi-professional group working across the trust to review quality and share cross-site learning. This seemed to work more effectively for obstetricians than midwives who were less aware of activity at other sites.
- A trust-wide MDT forum for fetal medicine met on a monthly basis to discuss current cases. This was attended by doctors of fetal medicine, geneticists, midwives, paediatric surgeons and cardiologists. A record of attendance was maintained as required by the national screening committee (NSC) and all data needed for the annual report to the NSC was compiled by the trust's screening midwife.

Seven-day services

- The hospital provided maternity services 24 hours per day, seven days per week.
- The full range of imaging services was available 24/7. However, there was no access to gynaecology scanning out of hours unless the doctor on duty had the skills to do this.
- Ante-natal and scanning clinics were offered from Monday to Friday, 9am to 5pm, with occasional additional clinics at weekends after bank holidays.
- Transitional care of babies enabled mothers to stay with their babies even when the baby required additional specialist care from special care nurses. A designated paediatrician was rostered each day for transitional care between 8am and 5pm and at other times the medical team on the NNU was available if required for these babies, although staff told us there could be delays out of hours. Relevant babies were seen on the night ward round by the paediatrician.

Access to information

- There were sufficient numbers of computer workstations in clinical areas with intranet and internet access for staff to use, for example to access patient information or trust policy documents. However, network-wide IT problems shortly before our inspection meant staff could not use many computers across the trust. At the time of our inspection only three out of nine computers were working on the postnatal ward. The trust was in the process of purchasing IT equipment and updating its computer software and systems.
- Staff had access to guidelines and policies on the trust intranet. Maternity guidelines had been updated and amalgamated for use across the trust. We checked a sample of five commonly used maternity guidelines and found they were up to date and had been reviewed against national guidelines. Staff we spoke with could explain how to find guidelines and policies.
- There was more than one database for recording women's antenatal screening results. For example, anomaly scans were stored on a separate database from blood results and nuchal scans. Staff therefore had to cross check results using different computer platforms which they found inefficient. Some test results were not remotely available to community midwives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The maternity service liaised with local adult social care services when assessing the needs of women with learning disabilities. This included discussions with social workers on patients' choices and their capacity to consent. Mental health awareness was included in the trust's corporate induction for new staff. It was not included as part of the trust's on-going mandatory training programme.
- Most staff we spoke with were not clear about their roles and responsibilities under legislation around capacity and deprivation of liberty safeguards. Staff responses were variable and several staff thought it was about health and safety issues.
- There were arrangements in place to seek consent for surgery and other procedures, including screening.

Patients we spoke with told us staff explained their treatment and care and sought consent before proceeding. We saw that consent forms were appropriately signed and dated in the notes we reviewed.

- We observed staff gave women who wished to have an epidural the epidural information card produced by the Obstetric Anaesthetists Association. This was available in different community languages to enable women who did not have English as a first language to give consent. However, some midwives told us that for other procedures, consent was not always taken properly where the consent form was not available in other languages.
- Staff told us some women decided they did not want any screening or scans and their choice was respected.

Are maternity and gynaecology services caring?

Requires improvement

We rated caring as 'requires improvement' because:

- Women's reported experience of care was mixed. Some women and families we spoke with reported poor experiences that included not being treated with dignity and respect, and having no continuity of care. They felt some staff focused on tasks rather than treating people as individuals.
- Women told us staff caring for them did not always work well together. Communication between staff and patients was not always effective. For example, some patients told us they were given conflicting information by different staff.
- Some women and their partners did not feel sufficiently involved in decisions about their care. Some family members did not feel they were proactively kept informed by hospital staff, and some women did not feel midwives helped them understand their treatment.
- Our findings about women's views of maternity care on inspection were similar to the results found in the 'women's experiences of maternity services' 2015 survey. These were poor, and scores at the hospital had fallen since this previous survey.
- Some women from some ethnic and cultural groups felt they experienced poorer care than others. We found some staff did not challenge cultural bias in their colleagues' behaviour.
- Local stakeholder organisations reported concerns about the way staff treated some women in the maternity services.

However:

- Women who had given birth at the hospital's birth centre were very happy with the way staff treated them, and appreciated the continuity of care they had from midwives.
- Some mothers we spoke with who had given birth on the delivery unit were positive about their antenatal care and delivery, and had found staff helpful.
- There was good perinatal support for women with mental health support needs, who were seen by a perinatal psychiatrist, a psychologist, a perinatal mental health nurse and midwives from the Gateway Midwifery Team.

Compassionate care

- At the last inspection women using the service reported mixed experiences of the quality of care at the hospital. Some women praised the kindness and friendliness of midwives and were happy to have given birth in the hospital. However, other women told us their care had been rushed and lacked compassion. Some women, for example those waiting triage, reported long waits up to three hours to be seen, and some felt midwives did not treat them with empathy at a time when they were feeling anxious. The trust had also scored poorly across a number of indicators in the CQC's 'Women's experiences of maternity services' survey 2015, which surveyed women who gave birth in February 2015. The trust scored lower than in the previous year and the average score to all questions was worse than the national average. However, there has been no survey since this date to track any progress on improvement.
- During this inspection women reported variable experiences about their care. Women who had given birth at the birth centre were happy with the way staff treated them there and appreciated the continuity of care that midwives gave them. However, some women told us staff caring for them did not always work well together. Communication between patients and staff was mixed. For example, patients were being told one

thing by one nurse and then something different by another. We were given an example by one family of the contradictory advice they had been given by nurses on the ward. When they had done what they were told to do, another nurse then chastised them for doing it. This had made them feel more worried and anxious and made them reluctant to ask questions.

- A Tower Hamlets Healthwatch 'trends analysis' report in 2017 highlighted patients' comments on staff attitude were 'broadly negative' and, with the exception of clinical treatment, which received mixed reviews. Responses to most aspects of the care pathway were negative. We were provided with an updated Healthwatch report and trends analysis for the period April to September 2017 which had 105 responses. It found positive improvements in staff attitude, quality of service and level of support. patients were less satisfied with waiting times and difficulty getting through to reception to book or cancel appointments.
- The results of the trust's Friends and Family test were also mixed although responses had improved from 8% in November 2016 to 13% in June 2017. The service had recently adopted an externally developed model to seek continuous feedback from women. This included a computer application available in community languages in which people gave feedback about their experiences. The intention was to enable quicker management of any concerns that were raised and focus on the outcomes women thought were most important. However, it was too early to ascertain its benefits.
- Some midwives told us were aware of stereotyping by their colleagues and that women were not always treated equitably with regard for ethnicity or socio-economic status. They found it difficult to raise this issue with their managers or challenge their colleagues.

Understanding and involvement of patients and those close to them

- At the last inspection some women and their partners felt that they were not sufficiently involved in care planning or decision making. Women told us they had received conflicting advice when they had seen different midwives and doctors during their pregnancy. This meant it was difficult for women to develop confidence in staff. During this inspection we received similar feedback.
- Several women mentioned receiving inconsistent messages from staff about infant feeding during their short stay on the postnatal ward.
- As a trust policy, interpreters were only available for face to face appointments that were over 30 minutes long. This meant that some women could find it difficult to gain enough information from their shorter appointments and staff commented that when they used a telephone interpreter service this reduced discussion time further.
- For mothers to share in decision making, access to interpreters or information in their preferred language needed to be available so that mothers could understand sufficiently. This would ensure women and their partners could make informed decisions about the benefits, risks and consequences of their choices. Staff told us they regularly used family members as interpreters to ensure they collected and shared the information they needed with women. Managers told us that involving mothers in decisions about their care was a key action for 2017.
- A maternity audit of 100 women who had had a caesarean between February and April 2016, found the majority of women were happy with their care in theatres. Overall patients stated staff in theatre were very professional, competent and friendly and comments such as "they put me and my partner at ease" were reflective of this.
- Less positive comments were received about care in the postnatal period. Women reported not knowing who was looking after them. Comments that the ward was very busy and that staff were unfriendly were reported. Women felt unsupported and the post-natal ward was short of staff to take care of all patients.
- After birth, partners and the patient's own children were welcome to visit between 8am and 8pm. Other guests wishing to visit were asked to come between 2.30pm and 8pm to enable women to rest and have some private time with their new born. There was a limit of two visitors plus partner at any one time. This also allowed for midwifery care and assessments during the morning.
- Staff and women mentioned a lack of privacy in the triage area which meant that sensitive conversations in triage were not held in private. The layout of triage meant there was no available space to have private conversations when asking women why they had attended the hospital.

Maternity and gynaecology

Emotional support

- There was good perinatal support for women with mental health support needs, who were seen by a perinatal psychiatrist, a psychologist, a perinatal mental health nurse and midwives from the Gateway Midwifery Team.
- A birth reflections clinic was run once a month by a consultant midwife and a psychiatrist and this provided an opportunity for women to discuss what had occurred during their labour.
- Women who had suffered foetal loss or stillbirth were offered debriefing and counselling. The service was culturally sensitive to the needs of different women and their families. Women could be referred to a local support charity for advice and support. In the event of a baby's death, the family was given a named link with the hospital, who was either the bereavement midwife or a supervisor of midwives.
- A multi-faith chaplaincy offered a bereavement service and emotional support to families that needed it.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- Staff reported regular difficulties meeting demand in the maternity unit. This caused some delays, including in planned induction of labour and in elective caesarean sections.
- There was an inconsistent approach to translation and interpreting services and inadequate provision of written information for women and their families.
- Systems and processes in place were not effective in in identifying non-English speaking women attending the maternity service. Staff did not always have adequate time to explain things properly to women who were not fluent in English because of the time it took to access translation services as these were not pre-booked in advance.
- Not all women received continuity of midwife care from a named midwife. Many women and their families did not feel the maternity service was addressing their individual needs.
- The flow through triage and the delivery suite was poor because of a shortage of staff and postnatal beds.
- Women experienced waits for care throughout their maternity experience. Senior staff were aware of delays to discharge from the postnatal ward but this had not been audited.

However:

- Women could access antenatal clinics in a variety of locations and the one-stop booking clinic reduced the need for women to travel for their appointments.
- Women described good support around their choice of place of birth, including home births, and partners were welcome to stay.
- Perinatal bereavement care was sensitive and appropriate.
- There were specialist teams to support women who may require additional support or those with specific needs.

Service planning and delivery to meet the needs of local people

- The service treated a very ethnically and culturally diverse demographic of women from Tower Hamlets. 35% of the local population did not speak English as a first language and 57% of mothers giving birth at the hospital were not born in the UK. Over one hundred different languages were spoken in the hospital's catchment area. Senior managers told us this placed considerable demands on the service in terms of the need for interpreting services, understanding different cultural norms, sometimes complex health needs and a range of different expectations of health service provision. Staff said they often did not know if women could understand English until they presented in clinic, triage or labour. There were no systems in place to identify non-English speakers in advance of their first appointment.
- The trust employed six whole time equivalent Bengali advocates to support women from the local Bengali community. All of the advocates were women who were trained in discussing sensitive issues. They were based in the antenatal unit but worked other areas of the maternity service when needed. However, some staff told us demand for advocacy support outstripped what was available. There was no comparable support system for women from other communities.

- There was a 'one stop shop' booking clinic staffed by core clinic and community midwives which enabled up to 55 women a day to have their initial appointment (booking appointment). Medical history, scans and blood tests were completed in one appointment, reducing the need for many women to attend the hospital multiple times. We saw that the high throughput of patients led to some congestion and queues in the antenatal waiting area but the process was effectively managed. This clinic helped the service meet its target for booking women by 12 weeks and 6 days. There was no option for women to have their initial appointment at a location in the community.
- There were play areas for children in maternity clinics.
- There were two triage areas. One in the Lotus Birth Centre for low risk women and the other on ward 6 E/F for women presenting with risk factors.
- There was a lounge for women who were in the early stages of labour on the delivery suite to remain in hospital instead of travelling home. It provided limited privacy, but we were told that some women had given birth there.
- A number of the single rooms on the postnatal ward could be used as amenity rooms where women could pay for the use of a single room. The Lotus birth centre had three single ensuite postnatal rooms.
- All birth partners were able to stay with women for as long as they were in labour which included overnight stays.
- There was a 37 bedded NICU which provided ITU and HDU cot capacity as well as resuscitation services to the maternity unit. The hospital also hosted the London Neonatal Transfer Service which could provide rapid transfers in and out of the unit should they be required.
- Full year data for the number of women treated in HDU was not available. In the two months between April and June 2017, 222 women were admitted to the unit.

Access and flow

- We asked the trust for information on the percentage of women in labour seen by a midwife within 30 mins and the percentage of women seen by a consultant within 60 minutes during labour. The trust did not routinely capture this information as this was not a national standard they were aware of. Such information is routinely collected by many other maternity units and is good practice as its gives assurance that all women presenting in labour were appropriately risk assessed, and seen by the relevant professional in a timely way.
- Information on the percentage of pregnant women accessing antenatal care seen within 10 weeks compared with percentage seen within 20 weeks was unavailable.
- Triage was carried out on the delivery suite. The target was for midwives to give an initial assessment within 15 minutes, and to prioritise women for full assessment according to a risk rating. Midwives told us it was difficult to achieve this time target at night when there was only one midwife on duty. Information on whether these targets were achieved was not recorded on the maternity, women's and children's performance scorecard.
- Flow through the maternity unit was impacted by insufficient availability of postnatal beds. There were no fixed allocation transitional care (TC) beds on the postnatal ward and all babies requiring TC were nursed there. We were told that sometimes up to 22 beds might be used for transitional care. Some vulnerable women also needed to stay longer on a postnatal ward, which further impacted on flow for women who had delivered and were waiting for a bed.
- During our inspection there were some women in HDU beds who did not require HDU level care because there were no other beds available. Other women were kept on the delivery unit for 12 or more hours after delivery due to the lack of postnatal beds. This could impact on their care because midwives in the delivery suite were focused primarily on the care of women in labour.
- At the previous inspection staff told us that diverting women to give birth at other hospitals in the trust was often considered. The unit diverted women when they ran out of beds and/or staff to care for women in labour and postnatal women. There had been nine closures of the maternity unit between April 2016 and September 2016 due to capacity issues. However, staff on the delivery suite considered that diverts should be put in place before the unit reached capacity to improve the experience for women already on the ward.
- Staff told us the discharge process was cumbersome. Midwives told us it took 30 minutes to generate a six page report for GPs and community midwives. This

reduced the time they could spend with women and families explaining going home and follow up appointments. Staff told us other delays were caused by the wait for medicines to take away.

- A system was in place to monitor mother and baby discharge. Mother and baby were 'signed out' by the ward clerk who counter-checked against the ward list and paperwork provided by the midwife. However, the service did not audit postnatal ward discharge times.
- Women could self-refer to the service by telephone or online, or they could be referred by their GP. Women referred from outside the area were seen at antenatal clinics in the maternity unit.
- The service encouraged local GPs through meetings and written communication, to refer women earlier to the hospital so they could have timely critical screening tests as recommended by NICE guidelines. All referrals from GPs to the hospital booking clinic were made through the antenatal clinic reception and were vetted by clinic staff to ensure appropriate clinical review.
- During our inspection delays were a theme of complaints and comments by patients. Staff were aware of these issues and had taken on more reception staff to help with clinic delays. Staff said the opening of the Lotus unit in November 2016 had made a big difference in reducing delays. It had reduced pressures on the labour and postnatal wards and improved capacity and flow.
- Elective caesarean lists took place every Tuesday, Wednesday and Thursday between 8am and 1pm. The dedicated elective theatre was staffed by a consultant anaesthetist, a consultant obstetrician and a full theatre team, all of whom were allocated to the elective list and not part of the acute labour ward team. From 1 August 2017, the Wednesday list was to be an all-day (8am to 5pm) list with capacity for 5 patients.
- Some sessions for planned caesarean sections were over booked which could often cause delays for women. Inductions were also often over booked which meant some women were not able to have their induction on the expected day, which could cause distress.
- The day assessment unit (DAU) was open from 8am to 8pm and saw women who presented with concerns, including rupture of membranes, bleeding, reduced fetal movements or high blood pressure, without an appointment and acted as a triage area during the day.
- There was an area women could wait in before they went home, with comfortable seating and information leaflets for women to take away. This helped flow because beds were vacated earlier. Mothers and their babies were not discharged after 8pm at night.

Meeting people's individual needs

- Women were given an information pack when they were booked for maternity services. They were also given a comprehensive discharge pack, which included advice on breastfeeding and how to identify a sick baby.
- The Bilingual Heath Advocacy and Interpreting Service (BHAIS) had developed different ways to respond to the needs of minority communities. In addition to its advocacy and interpreting role, it had been involved in language specific sessions, for example on diabetes, smoking cessation, parent craft and language specific clinics.
- Staff were able to book interpreters to communicate with women who did not speak English as a first language but this required 48 hour notice. For appointments less than 30 minutes a telephone interpreting service was used which staff and women said was slow.
- There was a range of leaflets in English that covered a number of topics including care in early labour. However information was not always displayed where it was most useful. A number of the leaflets on the postnatal ward were for antenatal mothers, and those with complex needs, rather than being focused on the needs of women who had already given birth.
- Almost all of the service's written information was in English and although the large range of leaflets explained where to obtain translation, we saw no signs in other languages in the maternity area to explain how to obtain information in other languages. Staff explained this was because many women using the service were not literate in their own language. The only information we saw in another language was information about epidurals, and a recruitment campaign seeking women for research studies.
- Managers told us women in established labour were transferred to a single ensuite birthing room where they received one to one care in labour. Women identified as low risk and having outpatient induction would have

done this in the Lotus birth unit and if they went into labour spontaneously they would also birth there if safe. However, if they required further intervention they would be admitted to the delivery suite.

- Women birthing in the obstetric unit were transferred to the postnatal ward following the birth. Women who were low risk and who wished to transfer home could do so after 6 hours directly from the room in which they had their baby. This would prevent an unnecessary transfer to the postnatal ward.
- Depending on clinical need women were streamed into low risk (midwife-led) or high risk (consultant-led) pathways. Low risk women were offered the options of birth at home, on the low risk labour ward (6E) or at the birth centre. The community midwife undertook all antenatal care. A variety of specialised clinics were run in the hospital for those whose pregnancies were higher risk.
- Women considered to be high risk were induced in the induction area which consisted of single ensuite rooms so that privacy was maintained at all times. Once women were in established labour, they were transferred to the adjacent obstetric unit for 1:1 care in labour.
- Women who had chosen the midwifery birthing unit told us they were happy with their choice of birth location and had been offered a tour of the birth centre in advance.
- Continuity of care was not available to most women planning to give birth in the hospital. Women planning to use the birth centre or have a home birth reported having continuity of midwife care. Some women said that although they had a named midwife they would see different midwives and doctors at every appointment. Some women on the postnatal ward told us they had seen different midwives each day on the postnatal ward. This was confirmed by staff.
- Allocation of staff was done daily and dependent on staff numbers and skill mix. Staff could be moved to other units if there were shortfalls. This impacted on staff continuity for women on the wards.
- The antenatal unit and the fetal medicine unit shared a counselling room. Staff told us this often meant staff had to discuss sensitive scan results with women in the scanning room itself, which was not a suitable space for potentially sensitive conversations.
- The hospital provided facilities for patients and their relatives to use as a quiet space for prayer or contemplation. This included a sanctuary mainly used for Christian services, a Jewish community room and Muslim prayer rooms with ablution facilities. Chaplains attended MDT forums including the pregnancy loss group meetings. They worked closely with palliative care and maternity services. The chaplains worked with the bereavement midwife where required in supporting mothers who suffered a miscarriage or stillbirth. They also delivered training to staff, and organised and lead memorial services.
- There were two bereavement rooms on the delivery suite dedicated to bereavement care for families and a counselling room on 8E. This was mainly used by the MFAU/FMU team.
- There were various information posters on the walls in the antenatal clinic and lots of leaflets on a range of subjects. For example, eating well in pregnancy and information and contact information for various agencies and support networks.
- Notice boards in ward corridors contained information for patients and relatives, including number of births, health and safety information, protected meal times and senior nurse contact details. However information was not available in any other language than English.

Learning from complaints and concerns

- There was a trust complaints policy and leaflets were available in maternity areas explaining how to raise a concern or give positive feedback.
- We saw there were many thank you cards on display on the wards which expressed gratitude to clinicians involved in patients' care.
- To accommodate patients who did not speak English as a first language, the trust had systems for patients to submit complaints in their chosen language and for the complaint and response to be translated for both the patients and professionals responding to it.
- For the 12 month period from January to December 2016 the maternity service received 57 complaints. The leading cause of formal complaints was poor communication (32%), which included women's understanding of the information provided. Other themes identified were rushed appointment and lack of compassion from staff.
- For the period December 2016 to June 2017 the maternity service received 60 complaints. This was more than for the whole of the previous year. The main

themes related to staff attitude, poor communication and delays in care. During this inspection some women told us they still had concerns about staff attitudes and behaviours.

- There were delays in responding to complaints in a timely way. Managers said complaints and concerns were addressed whenever possible at the time they were raised and that they tried to deal with complaints locally and as quickly as possible. Managers had identified problems with the IT systems notification processes. They were working on ways to ensure complaints were directed to the right people so they could be responded to quickly to prevent delays.
- The trust's complaints policy documented a 25 day timeframe for responding to complaints. However records indicated that 30 of the 60 complaints were overdue.
- Resolution of complex complaints was supported by meetings between staff and patients. When complaints were linked to a serious incident investigation in maternity services, women or their partners were given a named contact and there was a process to make sure they were kept fully informed of the results of the investigation.
- Women and their families were encouraged to provide feedback on their experiences. However we spoke with one family who told us they were reluctant to share their negative experience of care until they left the hospital.
- The maternity service used a number of methods to ensure that learning from complaints or concerns was shared with staff. Themes from complaints and incidents were shared with staff through regular newsletters. Themes were also presented at the monthly maternity quality safety and assurance meeting. Consultants held a weekly safety meeting which included local learning from complaints. Although there was some evidence of service improvement as a result, there remained consistent themes of poor communication, delays in care and consistency of advice.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- Improvements were not always identified to ensure high quality care and action was not always taken in a timely way.
- Staff felt they were not always consulted and changes were often top down directives. Where changes had been made to the staffing establishment, the impact on the quality of care was not fully understood in advance.
- Senior leaders of the service were taking action on historic challenges with organisational culture and unprofessional behaviours such as bullying. These were still evident in the service which needed to be further addressed.
- Whilst some improvements had been made, systems to monitor the security and safety of babies and mothers were not effective and unauthorised access to the wards was still occurring.
- Arrangements for governance and performance management did not always operate effectively. There remained inconsistencies in the way some data was collected and reported, which impacted on its accuracy and reliability. Systems were not always effective enough in monitoring the outcomes of incident reports.
- The trust was aware they had a backlog of incidents but were unclear how these were followed up or how the trust assured actions were completed.

However:

- Changes to site level leadership and governance structures had enabled service leaders to focus on addressing site specific challenges. Some progress had been made in response to concerns raised by the CQC in previous inspections in January 2015 and July 2016, with some improvements in midwifery staffing and capacity.
- The quality improvement board helped to drive improvements throughout the maternity service. There were goals, action plans and regular reviews of the service improvement plans.
- Morale among many midwives had improved since the last inspection.
- The medical and midwifery staff at the hospital were committed to providing a safe and effective service for women.
- Communication between managers and maternity staff and midwives, which had deteriorated at previous

inspections had improved. The majority of staff were positive about changes, but they identified some cultural issues and ineffective management styles as barriers to change.
- Some systems to identify manage and capture risks and issues had improved. A site specific maternity risk register was in place, and action plans to address concerns from previous inspections had mitigated and reduced some risks.

Leadership of service

- The chief nurse was the designated board member for maternity services.
- At the last inspection we found managers did not effectively engage with midwives on strategic changes to the service. Some staff we spoke with on this inspection felt there were still too many initiatives imposed from above instead of focusing on improving basic care for women.
- A site based leadership model was established at the hospital in September 2015. In June 2016 four divisions were formed, including the Women's and Children's Division, which managed the maternity service.
- To strengthen local leadership the Women's and Children's Division was now split into three service lines: women's health (neonates, fertility and gynaecology), maternity services and children's services. Each of these had their own general manager, senior nurse or midwife and clinical director. Some of the staff in leadership positions had worked at the trust for a long time but were newly appointed to their respective posts.
- At the previous inspection senior managers and clinicians told us the site based and divisional leadership model supported appropriate focus on site specific challenges and areas for development. They felt it created a more responsive leadership structure. For example, we were told that previously obstetricians did not have voice in management but the new structure, with a budget, had enabled them to make some long awaited changes such as increasing consultant cover on the delivery suite. During this inspection managers were positive about the new leadership model. Senior managers in maternity said they had good access to the hospital leadership team. The medical director was visible and supportive. The clinical academic group (CAG) had a strategic role but operational, financial and governance responsibilities lay within the division.
- At the last inspection staff told us the trust's centralised HR services did not support service managers to make improvements, such as timely recruitment of new staff. Slow recruitment processes were considered as a factor in unfilled midwife vacancies and not achieving safe staffing levels. During this inspection managers told us HR processes had improved. HR contacts were more responsive and processes were in place to ensure systems worked smoothly and delays were minimised. This had resulted in a successful recruitment campaign and reduction in the number of vacancies from 32 clinical midwives to 19.
- Leaders of the service demonstrated steady progress in recruiting more midwives and improving morale since the last inspection, but there was recognition that there were still a number of areas that required further improvement. Senior leaders of the service identified the most prominent of these as developing the organisational culture, including improving relationships between teams, services and external stakeholders and women using the service.

Culture within the service

- At the last inspection we found limited evidence of team working among midwives. Staff told us various things had not been done because someone was on leave, or off sick and no one else picked up the responsibility. More than one midwife told us that on occasion they did not receive support from colleagues when they asked for it. During this inspection staff said whilst there had been some improvements to team working this very much depended on who they were working with on the shift. Several patients commented that staff were unhelpful and were reluctant to raise issues.
- By contrast, we were told medical staff worked as a close knit team with a culture of providing mutual support and a willingness to seek and provide advice and support. This was confirmed by all of the medical and nursing staff we spoke with during this inspection.
- At the last inspection we found that limited understanding of different cultural norms, behaviours and expectations was a barrier to staff cohesion and improving women's experience of maternity care. We saw evidence that some women were treated less favourably than others. Some staff perceived that their cultural background meant they were overlooked for promotion. Several staff felt the reason for high staff turnover and student midwives leaving after

qualification was consequence of cultural issues causing tensions on the wards. During this inspection, some staff told us that limited mutual cultural understanding continued to have a negative impact on patients and staff.

- At the last inspection midwives on wards and in the community told us they felt unable to challenge unprofessional behaviours and attitudes of some colleagues and on this inspection they raised similar concerns. Some midwives we spoke with told us about bullying behaviours between different groups of midwives and towards some ethnic groups.
- We were told by some staff that not all managers were aware of some of the unprofessional behaviours of individual members of staff. During this inspection some managers we spoke with were aware of cultural issues, for example, individual members of staff not speaking to patients in a respectful manner. Some staff told us managers were taking action to address bias and unprofessional behaviours, but they felt that changes were not robust or rapid enough.
- At the previous inspection we found a directive, 'top down' management approach caused some discontent amongst some members of staff. Midwives in the delivery suite and wards did not feel respected or appreciated by senior managers. Some staff felt their concerns were not listened to, and that management had little interest in their well-being. Late approval of annual leave requests and late staffing rosters were cited as examples.
- However, on this inspection we found there was significant improvement with several staff telling us morale had improved and several staff told us they "loved coming to work". Communication between managers and maternity staff and midwives, which had deteriorated at previous inspections, had improved. Midwives felt they were listened to and morale had improved**.** The majority of staff were positive about changes. Many changes had been implemented in response to staff complaints after the last inspection.
- Several staff commented that managers were now more concerned about staff wellbeing, were more approachable and that there was an open culture. Managers were visible and did regular walk arounds.
- Staff sickness and other absence had reduced from 23% in June 2016 to an average of 4.3% between November 2017 and April 2017.
- At the last inspection we found low staff morale among midwives, both in the community and on the wards. Staff we spoke with on this inspection were mainly positive about changes that had been put in place since the last inspection. Regular bank and agency staff were used to supplement permanent staffing and recruitments days were attracting candidates to fill vacancies and this was having a positive impact on workload and work intensity, which was having a positive impact on staff morale.

Vision and strategy for this service

- The trust's maternity review proposed a plan to transform maternity and new born care services for women. This included ensuring women had continuity of care, with a named midwife and developing a culture that empowers midwives.
- The plans included widening choice across clinical commission group (CCG) boundaries with clusters of CCGs working together to establish service specifications. Working with new providers to offer maternity services across their combined localities, offering women more choice of providers to meet their needs and preferences, and empowering women to take control. It also included developing and implementing arrangements for women to take control when deciding who provides the services they wish to access.
- We were told that partnership working with other organisations was developing under the Transforming Services Together (TST) programme. This programme was run jointly with three CCGs (Newham, Tower Hamlets and Waltham Forest) with the purpose of improving care, offering choice and making sustainable changes.
- The TST programme aligned with the priorities in Better Births Improving Outcomes of maternity services in England (2016). As part of this, the service was seeking to promote maternity services across local populations and GPs, to ensure more maternity services were available outside of a hospital setting. The midwife-led delivery unit (AMU) that opened in November 2016 was part of this plan and was expected to take 30% of births. Over the six month period November 2016 to April 2017 it had taken 8% of births. Staff told us this was because there were few new staff and current staff rotated across units.
- There was an annual business plan for maternity. Managers told us that strategic planning had taken

second place to reorganising services into site-based divisions with their own local governance and management structures. Key leadership staff were now in place so developing vision and strategy would be a priority.
- There were varying degrees of awareness of the future plan among the ward staff we spoke with, particularly more junior staff.
- At the previous inspection the high level vision had been for women and babies to have safe, excellent care. The trust had made progress in increasing the number of midwives and consultant obstetricians which was fundamental to achieving this. Senior managers were confident about the strategy and plans they had put in place to improve maternity services; however there was limited involvement of midwives working clinically in developing strategy. Decisions were made at manager level and the majority of staff felt they were not involved. Staff commented that whilst staffing levels had improved they were not involved in decisions being made or how they should be implemented.
- Some staff were concerned that there was a risk that financial pressures could undermine quality care.

Governance, risk management and quality measurement

- Managers told us that governance systems and processes were being developed as the new management structure was embedded. Governance structures in both maternity and gynaecology were still not fully aligned to site and divisional structures.
- A monthly performance review meeting scrutinised incidents, finance, the cost improvement programme, the maternity dashboard and investigations and complaints. However, it was unclear how effective this was in ensuring complaints were responded to within the 25 day timeframe as 30 of 60 complaints were overdue a response.
- The service did not always follow trust policy on incident reporting, categorisation and ensuring outcomes were promptly actioned. Systems were not always effective enough in monitoring the outcomes of incident reports. At the time of our last inspection the hospital had a backlog of reported incidents waiting for action to be completed. We saw that incidents could show as closed on the quality assurance incident database even though outstanding actions were still to be completed. The trust was aware they had a backlog but were unclear how these were followed up or how they were completed. We were not assured that where changes were made, the impact on the quality of care was sufficiently monitored.
- The governance dashboard information recorded serious (SIs) with actions overdue. There were 26 SI actions overdue in May 2017. Three SI reports we looked at had identified actions to be followed up. However, it was unclear how these were being monitored or reviewed to ensure actions had been completed. Overdue actions for SIs were not included as a risk on the maternity risk register.
- There were seven obstetric risks on the hospital's risk register with security of maternity areas, and obstetric consultant presence on the delivery suite scoring a high risk rating. Midwifery staffing shortage had reduced from high to moderate risk and baby ID from moderate to low risk. Arrangements for governance and performance management did not always operate effectively. There remained inconsistencies in the way some data was collected and reported, which impacted on its accuracy and reliability. Not all systems to identify manage and capture risks and issues had improved. In the previous inspection we raised concerns that there were no checks on who was visiting the postnatal ward and inconsistent enforcement of visiting hours. Whilst some improvements had been put in place, systems to manage these risks were not sufficiently effective to ensure baby security on wards.
- Site level clinical governance structures were in place with monthly governance meetings. There were meetings and forums to monitor quality, review performance information and to hold service managers and leaders to account. However, decisions were made at manager level and the majority of staff were not involved in discussion about the impact on patients and how they should be implemented. Staff told us that where changes were made, the impact on the quality of care was not fully understood in advance.
- The divisional team was responsible for overall governance, including maintaining the risk register and ensuring complaints were handled appropriately. The division reported through the divisional performance review to the site leadership team. There were three dedicated governance leads (one per service line) that

were responsible for supporting governance. They fed into the wider team of service managers, senior nurses and midwives, clinical leads, matrons, and general managers, who were all responsible for governance.
- Weekly governance meetings were held with the clinical leads for anaesthetics and peri-operative medicine, the governance lead for obstetrics and the band 7 for obstetric theatres. These covered risks and concerns. Minutes were shared by email with all paediatricians and anaesthetists.
- The maternity and gynaecology services were part of the women's and children' division. Women's health covered fetal medicine, maternal medicine, the maternity HDU, obstetrics, midwifery services, gynaecology and reproductive medicine. Theatres were managed separately by the surgery division.

Public engagement

- At the previous inspection we were told the maternity service had held a meeting with commissioners and local GPs in May 2016 to try to address some local misperceptions about care and quality. Around 40 GPs had attended and staff felt this was successful in raising awareness of issues involved in optimising normal birth.
- One of the recommendations of the Tower Hamlets scrutiny committee (June 2016) had been for a review of the trust's midwife recruitment strategy to increase the diversity of staff to reflect the cultural make-up of the local population. Another recommendation was that staff should allow sufficient time for staff to provide information to patients, particularly for women who did not speak English as a first language. However, during this inspection we found that some women still did not have a favourable experience and staff confirmed that they still did not have the time or resources to ensure all women had the support they needed.
- There were a number of patient involvement initiatives taking place. However, staff raised concerns about whether there were enough volunteers to represent the diverse communities who used maternity services at the hospital.
- The maternity services liaison committee had recently changed its name to the Maternity Voices Partnership which aimed to involve local women in shaping the future of maternity services in the borough. It was supported by Social Action for Health, a community development charity which worked alongside marginalised local people and their communities.
- A new project called 'midwives understanding mothers' sought to improve intra-cultural understanding and provide more person centred care. There was also a lead midwife for patient experience, who had been in post since September 2016. In addition, there were other patient experience initiatives in place. They included ongoing workshops in relation to the experience of partners during pregnancy, Listening into Action events on patient experience, questionnaires relating to elective c-sections and improvements to the website being done in partnership with service patients and their relatives.

Staff engagement

- Many staff we spoke with on this inspection said management changes had improved morale and they were now more involved in developing services. Several staff said they felt valued and listened to by their managers. However some midwives told us their colleagues had left the hospital because they continued to perceive a lack of support and that management did not listen to concerns.
- On the previous inspection midwives commented that senior midwifery managers were not visible and did not work clinically. During this inspection we received mixed responses from staff about this and that senior managers were more visible in clinical areas.
- Some staff said they were encouraged to raise concerns; however others commented that it made no difference as they did not feel it resulted in changes.
- In the most recent trust-wide staff survey the hospital performed better than the trust average on appraisals, learning from errors, staff feeling secure about raising concerns and had the second highest engagement score of all sites. However, experiences of bullying, harassment, abuse, violence and discrimination from patients or members of the public was identified as a cause for concern. The trust was focused on engaging staff to agree which areas to focus on and some work on this had commenced in the maternity service.
- At the last inspection the trust told us about a new programme they had introduced, called 'making every contact count' based on the six C's pledges of

compassion, care, competence, communication, courage and commitment. It was another attempt to improve compassionate care. However, during this inspection it was not clear how the outcome of this programme were being audited.
- 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.
- The trust had invested in commissioning support from an external agency to improve the working culture in the hospital. Part of this work involved regular staff meetings to help staff improve team cultures and the patient experience.
- Service leaders conducted staff surveys were underway to help identify reasons for high staff turnover. They used information from the surveys to introduce plans for improving staff retention. This included reviewing rotation programmes.

Innovation, improvement and sustainability

- The service had won an award for the use of manual and vacuum aspiration enabling miscarriage to be managed under local anaesthetic without needing to go to theatre. This reduced waiting times and uncertainty for women.
- My Body Back maternity clinic was set up with project volunteers for women contemplating pregnancy or who are pregnant. It was a charitable voluntary service for women who had experienced rape and sexual trauma. The new clinic provided advice about pregnancy and birth by empowering women to develop their birth plans and strategies in preparation for labour and birth.
- The maternity services managed a diverse range of services, meaning that women could access all their pregnancy support services easily and at a time and location that suited them. This included the midwifery led unit at the nearby Barkantine Birth Centre, the co-located Lotus birth centre and obstetric-led services.
- There were a number of innovative services such as My Body Back and Birth Reflections that were not offered by other hospitals in the UK.
- The maternity service won a number of awards including RCOG trainers of the year.
- Three of the hospital's consultant obstetricians were nationally recognised for excellence in multidisciplinary human factors training.

Outstanding practice and areas for improvement

Outstanding practice

- My Body Back maternity clinic was set up with project volunteers for women contemplating pregnancy or who were pregnant. It was a charitable voluntary service for women who had experienced rape and sexual trauma. The clinic provided advice about pregnancy and birth by empowering women to develop their birth plans and strategies in preparation for labour and birth.
- The service had won an award for the use of manual and vacuum aspiration enabling miscarriage to be managed under local anaesthetic without needing to go to theatre. This reduced waiting times and uncertainty for women.

Areas for improvement

Action the hospital MUST take to improve

- Ensure all security systems and processes are properly utilised and staff are aware of their responsibilities in this area to ensure mothers and babies are kept safe from unauthorised access to the units.
- Review all overdue serious incident reports and ensure that all required actions are completed and learning is disseminated in a timely way.
- Ensure governance processes for monitoring and reviewing serious incidents are applied correctly so that serious incidents are addressed in a timely way in future.
- Ensure there are sufficient numbers of experienced midwives to supervise and support less experienced staff and safely manage the level of acuity of women on the labour and postnatal wards.
- Ensure that all relevant staff complete children and adult safeguarding levels two and/or three to ensure compliance with the trust target of 90% completion.
- Ensure that the level of consultant cover on the delivery suite meets the trust target of 98 hours.

Action the hospital SHOULD take to improve

- The service should consider introducing the NHS maternity safety thermometer to more accurately assess risk specifically associated with maternity care.
- The service should ensure delivery suite coordinators have supernumerary status with sufficient allocated time and resources to carry out their oversight and support role.
- The service should take further action to ensure compliance with the trust's target of 90% completion of mandatory training.
- Consider auditing the percentage of women presenting in labour seen by a midwife within 30 minutes so as to be better assured that all women are appropriately risk assessed and seen by the relevant professional in a timely way.
- The service should assess demand for written information in languages other than English.
- The service should take further action to address the perceived culture of bullying and harassment among midwives.
- The service should take further action to improve cultural awareness of staff.

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 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided. Systems were not always effective in monitoring the effectiveness of changes to baby security or in preventing unauthorised access to the delivery suite and post-natal ward. The service must ensure systems to improve security are fit for purpose. Systems and processes were not established or operated effectively to ensure the provider was able to fully assess, monitor and mitigate the risks to the health, safety and welfare of babies. The trust were not always following their own policy on incident reporting, categorisation and ensuring outcomes were promptly actioned. The service must ensure arrangements for governance and performance management operate effectively. This was a breach of Regulation 17(2)(a) and 17(2)(b)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Providers must do all that is reasonably practicable to mitigate risks.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	The service must ensure that all staff compliance with children and adult safeguarding level two and three training reaches the trust target of 90%. This was a breach of regulation 12(2)(b):
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed to make sure that they can meet people's care and treatment needs. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in maternity services reflecting the establishment agreed as appropriate for the acuity of the women. This was a breach of regulation 18(1)