Barts Health NHS Trust

Whipps Cross University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Whipps Cross University Hospital

Requires Improvement 

The inspection was carried out as part of CQC's national maternity inspection programme. The programme aims to provide an up to date view of the quality of hospital maternity care across the country and a better understanding of what is working well to support learning and improvement at a local and national level. You can read more about this work on the CQC website.

This short notice announced focused inspection of maternity services provided at Whipps Cross Hospital who are part of Barts Health NHS Trust was on the 16 August 2022.

Barts Health NHS Trust provide maternity services from five locations these are the Whipps Cross University Hospital, The Royal London Hospital, Newham University Hospital and two standalone birth centres The Barkantine and Barking Birth Centre (also known as Barking Community Birth Centre.)

Whipps Cross University Hospital is in Leytonstone in the East End of London, within the London Borough of Waltham Forest. Services are aimed at a diverse population and included antenatal, fetal medicine, consultant led labour ward and the Lilac birth centre, postnatal and community midwifery services to the local population. From August 2021 to July 2022 there were 3,969 babies born at the hospital.

We also inspected 3 other Maternity services run by Barts Health NHS Trust. Our reports are here:

Barking Birth Centre – https://www.cqc.org.uk/location/R1H41

The Barkantine Centre – https://www.cqc.org.uk/location/R1HX7

The Royal London Hospital – https://www.cqc.org.uk/location/R1H12

Our ratings of the Maternity service has not changed the ratings for Whipps Cross Hospital overall. We rated safe as requires improvement and well-led as good.

Maternity

Good ➔➔

Our rating of maternity services is good because:

- Hospital staff received training in key skills, and worked well together for the benefit of women, they understood how to protect women from abuse. The service controlled infection risk well. They managed medicines well. The service managed safety incidents well most of the time and learned lessons from them.
- Staff felt mostly felt respected, supported, and valued. They were focused on the needs of women receiving care. The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to continually improving services.
- Leaders provided effective interpreting services and maternity bereavement services tailored to meet the needs of bereaved families.

However:

- The service did not have enough staff to care for women and keep them safe. Community staff and medical staff did not complete mandatory training within trust targets, and not all staff received an appraisal. Staff did not always assess risks to women and babies in line with guidance. Records were not always up to date. They managed medicines well although did not have access to a pharmacist seven days a week.
- Leaders monitored the services but did not always make sure staff were competent to undertake extensions of their role. Not all staff were clear about their roles and accountabilities because some policies did not exist, and new processes had not been implemented.

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however not all staff completed it.

Staff received and kept up-to-date with their mandatory training, the service published its annual training programme at the beginning of the year, this was accessible to all managers and staff via emails, letters, and shared drive. The training programme was also displayed on education boards within the unit.

The mandatory training was comprehensive and met the needs of women and staff. Training was divided into trust wide mandatory training, maternity specific modules, and multi-professional obstetric simulated emergency training.

Maternity

Not all staff received their mandatory training, the service provided evidence which identified training compliance ranged between 83.5% for community and 100% for the midwifery led unit. Leaders told us they recognised the challenges to completing eLearning modules during a busy clinical setting and were looking at strategies to improve this.

Maternity specific training included subjects such as antenatal and newborn screening, diabetes in pregnancy, normality in childbirth, risk management, and smoking in pregnancy. The service provided training via a nationally recognised e-Learning. Records showed between January 2022 and July 2022 whilst 100% of hospital midwives had completed the training only 83.5% of community and staff 78% of all medical staff had completed this training, which fell short of the trust target of 85%.

The service provided multidisciplinary emergency simulated obstetric training to all staff in the unit. Modules included maternal and neonatal resuscitation, early recognition of critically ill women sepsis major obstetric emergencies and human factors. Training included a combination of E-learning and simulated skills and drills, and staff completed a competency test. Between January 2022 and July 2022, we saw compliance varied from ward to ward. For example, 100% of labour ward staff but only 67% of antenatal staff and 78% of all medical staff had completed this training against a trust target of 85%.

We saw 71% of community midwives have received emergency obstetric training. We also saw training rates varied for maternity care assistants and support workers between 100% on labour ward to 67% on antenatal clinic.

Staff received training on interpreting and acting upon outcomes of cardiotocograph (CTG) monitoring of the fetal heart. Staff accessed a nationally recognised E-learning package on CTG interpretation, which was comprehensive and covered fetal monitoring and maternity crisis management. Staff completed a competency test at the end of the training to make sure that learning was embedded. Records showed 100% of antenatal, labour ward and midwifery led midwives were compliant with this training.

The service monitored mandatory training and alerted staff when they needed to update their training. The practice development midwives and college tutors were responsible for making sure staff were booked on annual mandatory training. Also, training records were monitored monthly, and reports submitted to the maternity safety assurance and quality committee.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. However, not all staff had required training on how to recognise and report abuse.

Midwifery staff had not all received training specific for their role on how to recognise and report abuse. We saw 81.2% of midwives were trained to level 3 safeguarding which was below the trust target of 85%. We saw the training level provided to staff complied with the intercollegiate guidelines (2019).

Medical staff had not all received training specific for their role on how to recognise and report abuse, we saw 78.6% of medical staff were trained to level 3 safeguarding which was below the trust target of 85%. This did not comply with the intercollegiate guidelines (2019), which states that all staff planning care for children and adults must be trained and compliant in level 3 safeguarding. We were told the service was taking steps to address the low numbers of staff undertaking safeguarding training.

Support workers and administrative staff attended E-learning level 1 and 2 safeguarding sessions. Managers gave them protected time to complete this.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, women with learning disabilities (LD) were referred to the hospitals LD nurse who supported mothers to make informed decisions about their care.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a standard operating procedure to support staff when they identified mothers and families at risk of harm or abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff accessed and completed safeguarding referral forms electronically and liaised with the safeguarding lead, doctors, health visitors and the local authority to initiate action.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had invested in digital baby name tags which bleeped if babies passed the exit doors on the postnatal ward. During our visit the alarm was activated, staff responded quickly and stood at all exits. The tag alarm was connected to the security team who attended swiftly. Babies at risk of abduction were flagged during handovers.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Performance for cleanliness across the service ranged from average to good. Health care assistants completed quarterly inspections reports using a pre-populated app on a handheld smart device. Records for July 2022 identified the labour ward scored 80% for cleanliness which was under the trusts target of 85%. We saw the cleanliness scores for the Lilac birth centre the postnatal ward met local targets at 86.2% and the latter 85% in August 2022.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning logs were visible in all area's which staff signed when cleaning was completed. Housekeepers monitored toilet and bathroom cleanliness every two hours. Although, hand sanitising posters were not displayed in all areas, for example the day assessment service.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw there was enough equipment available for staff to keep patients safe. We saw varying degrees of compliance in hand hygiene audits between 26 July and 05 August 2022 70% on the antenatal and postnatal wards and 100% and the Lilac birth centre.

Leaders monitored nosocomial and sepsis infections. Records showed during May and June 2022 there was only one incidence of Escherichia coli (E. coli).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. We observed during busy periods staff were not always able to respond to calls immediately.

The design of the environment did not follow national guidance. For example, the layout of Triage meant that staff had to move pregnant women into the day assessment when the service was busy.

The service had suitable facilities to meet the needs of women's families, however we did note the ward was cluttered and there was a lack of privacy. The ward area was divided into antenatal and postnatal bays and included a six bedded induction of labour area. The service had several side rooms were available.

Labour ward had 11 rooms one of which included a birth pool. There were two high dependency rooms close to the midwife's station. There were two self-contained bereavement rooms contained a double bed and furniture which reflected a home from home calm setting and were located away from the main labour ward activity.

The obstetric theatres were co aligned to the labour ward; they were adequately equipped, and staff completed daily equipment checks.

Staff carried out daily safety checks of specialist equipment. Records identified that between 01 July and 16 August 2022 equipment checking compliance was 100%.

The service had enough suitable equipment to help them to safely care for women and babies, including CTG machines and resuscitaires which were available in all rooms on labour ward, antenatal and postnatal ward, and the day assessment unit. We saw there was a handheld ultrasound device for staff to use in the antenatal ward which allowed staff to confirm the presentation of the baby prior to commencing any intervention.

Staff on the postnatal ward had access to a bilirubinometer which is a non-evasive equipment that monitors babies for jaundice. This is in line with best practice guidance.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman using the up-to-date tools. Staff identified and quickly acted upon women at risk of deterioration.

Staff used nationally recognised tools to identify women at risk of deterioration and escalated them appropriately at each point of care most of the time. However, evidence provided by the service showed improvements were needed to the quality of risk assessments in terms of personalised care and support plans and risk assessment audits.

Maternity

Staff completed risk assessments for each woman during the antenatal period, on admission during labour and during the post-natal period. Staff used nationally recognised tools to assess and plan care throughout pregnancy, childbirth and during the postnatal period and reviewed these regularly, including after any incident most of the time. However, during our inspection we reviewed eight sets of patient records and found women's risk was not documented between booking and 36 weeks' gestation, which was not in line with national guidance.

Staff used nationally recognised care bundles to assess women during pregnancy. For example, the 'Saving Babies' Lives Version Two (2019), which is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together five elements of practice which are identified as best practice:

Reducing smoking in pregnancy

Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)

Raising awareness of reduced fetal movement (RFM)

Effective fetal monitoring during labour

Reducing preterm birth

We saw the service used 'Gap Grow' charts however, evidence showed trust-wide the 'Gap Grow' care pathway did not always conform to national guidelines. There was a timeline agreed to review the guidelines when the Royal college of obstetricians and gynaecologists publish their new guidelines which was anticipated to be six months following our inspection. At the time of our inspection there were no mitigations in place to ensure women were appropriately assessed.

Women assessed as being at higher risk of pre-term birth at booking were assigned to the consultant led care pathway.

The service provided a preterm birth clinic for women at risk of a pre-term birth. The service also provided a consultant led birth reflections clinic for women who experienced a traumatic birth in line the Ockenden (2022) recommendations.

The service had not fully implemented a process of continuous glucose monitoring for women at the time of the inspection. We were told funding had been secured and the service was in the process of recruiting a diabetic nurse at Whipps Cross University Hospital. However, during the factual accuracy process leaders provided evidence that since July 2022 women with type 1 diabetes were actively monitored in line with national guidelines and the clinic is overseen by 2 diabetic midwives. Leaders told us that they are in the process of recruiting a diabetic specialist nurse to support the service.

The triage unit did not use a standard operating procedure, nor did they use a nationally recognised triage assessment tool to ensure women were assessed appropriately on arrival and their care prioritised. We also saw there was not a robust system to record telephone triage, especially the time at which women contacted the triage service. We escalated this to the service at the time of inspection and received assurances from the trust that they had implemented a new telephone triage diary which included call times and advice given. The service told us they planned to monitor the use of the triage telephone log after two weeks of implementation and then monthly thereafter.

Maternity

Staff completed the Modified Early Obstetric Warning Score (MEOWS). We saw MEOWS charts were clear and identified women whose condition was deteriorating. During our inspection we observed, midwives escalated findings to doctors for review, however, we noted there were occasions when reviews were delayed due to capacity and medical and midwifery staffing issues.

Staff completed multidisciplinary (MDT) shift handovers in three key areas: Antenatal and Postnatal ward and Labour ward.

Staff knew about and dealt with any specific risk issues.

Staff monitored fetal wellbeing using a cardiotocograph (CTG) machine. Staff followed a standard operating procedure for completing CTG risk assessments. We saw evidence which identified staff used pre-populated stickers that followed national guidelines to assess fetal wellbeing. Staff used a fresh eyes approach to review CTG progress, and the trust had appointment fetal wellbeing midwives to support staff training and decision making.

The service used a maternal sepsis care bundle to identify women at risk of sepsis. We saw the trust flagged as an outlier for puerperal sepsis on four occasions between July 2019 and September 2021 through the national data submission. In recognition of this the service introduced a process to mitigate the risk.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Those identified at higher risk were referred to a consultant led perinatal mental health service for additional support.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had clear processes for staff to follow which included the contact details of the onsite and out of hours psychiatric liaison teams.

Staff shared key information to keep women safe when handing over their care to others. Staff in the day assessment unit (DAU) and Triage used an SBAR (situation, background, assessment, and recommendation) process to handover care to other areas. However, in three sets of records we reviewed in DAU, we found that staff had not completed the assessment and recommendation aspect of the forms. Staff on labour ward did not always use the SBAR tool to handover care to postnatal staff.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff on labour ward completed a transfer from delivery suite ward checklist when handing over care.

The service had a transitional care service on the ward for babies who needed additional care in line with the 'Avoiding Term Admissions into Neonatal units Programme' (ATAIN). However, the service had not implemented a newborn RAG rated risk assessment tool with actions boxes as recommended by ATAIN. This meant the service could not be assured all babies received the right level of treatment and infant feeding advice to avoid admission to the neonatal units.

The service did not monitor waiting times effectively to ensure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff in the triage and day assessment units did not always record the time of arrival or time seen in patients notes. This meant the service could not be assured women's care was prioritised appropriately nor that each woman was seen in a timely manner. Managers told us that they planned to implement wait times as part of the implementation of the new triage model in September 2022 to ensure arrival times were recorded consistently.

Maternity

The service aimed to avoid unit closures, however, between 06 June to 17 July 2022 there had been two intermittent/ temporary closure of the home birthing service and Lilac birthing centre.

Due to capacity and staffing concerns, staff told us there were times when managers had to make the decision to postpone care for women who were due to have an induction of labour or elective caesarean. The service had staggered admission times for women booked for induction of labour to ease some of the activity and managers completed a daily review of the elective caesarean operating. Managers reviewed women to prioritise the most urgent, then contacted mothers whose care could be delayed for a short period for example 24 hours. Staff gave women their new appointment time and advice in the event of an emergency.

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels to ensure key areas were staffed appropriately most of the time. The service gave bank and agency staff a full induction.

The service did not have enough midwifery or support worker staff to keep women and babies safe in addition there was high vacancy rates. Evidence provided by the trust showed there was a shortfall of 19 midwives within community and 25 midwives on labour ward. Overall, the maternity dashboard data for July 2022 identified the service had a midwifery vacancy rate of 52.19 whole time equivalent posts.

The service could not always provide one to one care during labour. Hospital data showed from August 2021 to July 2022 there were five months when the service flagged as moderate risk because staffing did not meet the standard of 95%.

Leaders used The National Institute of Care and Excellence ‘Safe midwifery staffing for maternity settings’ (2015) to monitor the amount of cancelled procedures. Records showed from the 01 of February to the 31 of July 2022, there was a 54% delay in continuing planned inductions of labour and a 2% delay in elective caesarean sections

Managers completed audits on staffing levels and records for 1 February to 31 July 2022 confirmed the lack of sufficient staffing featured in 69% occasions when care was delayed. Records showed staffing issues were ongoing. Managers attempted to backfill gaps in staffing with bank or agency; however, there were 447 (60%) occasions in the same period where this was not possible.

There was not always a supernumerary shift co-ordinator on labour ward to ensure staff were well supported and care was safe. This is one of 10 Clinical Negligence Scheme for Trusts (CNST) accreditation requirements. Records showed 34% of the time labour ward did not have this resource. This impact of this is that there is no objective oversight of capacity and acuity on the unit.

We saw evidence of a band 6 midwife acting as labour ward co-ordinator on labour ward, who did not have supernumerary status which goes against CNST Safety action 5. Women in early labour were inappropriately being cared for in triage with only one midwife on duty. Staff told us this was common especially at night when midwives worked alone.

The number of midwives and healthcare assistants rarely matched the planned numbers. Records showed average fill rates on labour ward for the six-month period February to August 2022 ranged averaged 75% for day shifts and 84% for night shifts.

Maternity

The service calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. Leaders used a national acuity tool to monitor and record the activity on the unit.

The service sickness rates had stabilised in recent months. Managers monitored sickness rates and provided a detailed breakdown we saw the sickness absence rate was 11.7% for labour ward, 2.8% for community and 9.4% for obstetric theatres at the time of our inspection.

The service used bank and agency staff to backfill shifts and requested staff familiar with the service. Managers authorised the use of bank and agency staff, although, agency staffing was kept to a minimum. Staffing data showed 30% of shifts on labour ward was filled using bank and agency staff most of the time. The service ensured all agency staff were orientated so that they understood the service, however, we requested evidence of this orientation and the service was unable to provide it.

The service adjusted staffing levels daily according to the needs of women in line with their escalation plan. Ward managers attended daily staffing handovers and discussed the acuity of their patients. Matrons were identified as the decision makers for staff moves within the unit. Staff told us if labour ward was busy staff were moved to support the number of women in labour however, this meant there was minimal staffing on the antenatal and postnatal wards.

We found the professional midwifery advocate (PMA) role was not embedded throughout the service. We were told leadership support was limited as the PMA's did not have dedicated time. We were also told; the lead role had not yet been defined and there were vacant posts. Leaders told us there were nine midwives currently being trained in the PMA role.

We saw evidence that at least one midwife who had completed additional training in high dependency care (HDU) was rostered on each shift the HDU unit.

Leaders provided evidence that they had various strategies to improve staffing. These included increasing the numbers of administrative staff across the whole maternity service including community.

Managers support for staff to develop through yearly, constructive appraisals of their work was not consistent. Records showed since July 2021, appraisal rates for midwives at band 5. 6. And 7 fell below 50%. Managers told us that the low compliance was due to staffing issues across the service. The impact of low appraisal staffs is that staff are not given opportunities to raise concerns, identify weak spots in practice or have meaningful conversations about career development.

Managers made sure staff received any specialist training for their role. The service employed 15 specialist midwives. The roles included but were not limited to; a midwife lead for fetal surveillance, a lead for bereavement, a diabetes midwife, a mental health midwife and an infant feeding midwife.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment most of the time.

Maternity

The service reported they had enough consultant medical staff to keep women and babies safe. The service had enough consultants to cover services. The service employed 17 consultants across the service, however, we found three of the posts were filled by locums. The consultant team provided 84 hours of onsite cover on labour ward which was in line with the safer childbirth (2007) standards for the number of births at Whipps Cross University Hospital.

The service always had a consultant on call during evenings and weekends Consultants were on site between 8 am and 10 pm five days a week and 8am an 1pm and 8pm and 10pm on Saturday and Sunday. Outside of these hours staff contacted consultants remotely.

The medical staffing did not match the planned numbers. Staffing numbers at specialist trainee and foundation grades were lower than planned, evidence showed there was a shortfall of nine junior doctors. There were various reasons for this, including maternity leave, recruitment processes for overseas doctors and long-term sick leave.

The service had strategies in place to reduce vacancy rates for medical staff.

The service made sure locums had a full induction to the service before they started work. Agency and locum staff received a condensed induction programme before commencing work and advised staff that it was their responsibility to comply with trust policy for induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Leaders ensured the medical skill mix was balanced. They had split obstetrics and gynaecological on calls, which meant one specialist trainee and one foundation year 2 covered obstetric services and one registrar and one SHO covered gynaecology. This had eased pressure on the on-call rota and ensured medical staff could be deployed throughout the hospital.

Managers supported medical staff to develop through annual appraisals. Doctors received an annual appraisal, evidence provided identified in July 2022 92% of medical staff had received and appraisal. This meant that doctors had a clear understanding of their role and responsibilities, although training compliance levels for doctors were lower than the trust target.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Consultants were responsible for supporting doctors to progress. Staff told us that they were well supportive in terms of their clinical work, they had access to multi-professional teaching, there was good dissemination of learning from events and incidents and doctors were given the chance to cover more senior roles for career development.

Records

Staff kept records of women's care and treatment. Records were not always clear or up to date. However, records were stored securely and easily available to all staff providing care.

The service used a combination of paper and electronic patient records. In the ante and postnatal period staff recorded care in the mothers' handheld notes and used proformas. During labour staff recorded care on the electronic patient record. This meant that records were difficult to maintain and audit. The inspection team reviewed 8 sets of notes during the inspection, we found that staff recorded care contemporaneously in the paper records, but the audit was time consuming because notes were not consistent.

We observed staff on labour ward admitted women on to the digital system, however, the time of arrival was dependent upon the midwife or ward clerk updating the time if records were written in retrospect.

When women transferred to a new team, there were potential delays in staff accessing their records. Staff told us that at the neighbouring location of The Royal London Hospital, staff recorded the ante/postnatal care electronically and labour care was handwritten. The impact of this is staff reviewing the care of women who cross site during busy periods may not have all the information they need to risk assess women.

Managers completed monthly record audits and records showed staff reviewed five sets of notes at each audit performed between March 2022 and July 2022. The audits highlighted omissions and areas for improvements. For example, not all staff signed records and documentation during labour was not always completed accurately.

Records were stored securely in most of the time. However, we saw handheld notes left unattended in the day assessment unit when staff were called away.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed the trusts standard operating procedure when prescribing medicines.

Staff completed medicines management training every two years, followed by a medicines management competency test. There were six eLearning assessment modules for staff to complete and these included but were not limited to, medicines management of Patient Group Directive (PGD) medicines, (a group of medicines that can be administered by midwives without the need for a doctor or nurse prescriber) and medicines management for nurses, midwives and nursing associates, and supply of pre-pack medicines. Records showed 89% of midwives had completed this training.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Doctors reviewed medication during pregnancy and gave women advice on the how to use it. On the ward staff completed regular medication rounds to make sure women had their medicines on time.

Staff did not always complete medicines records accurately or keep them up to date. During the inspection we reviewed eight prescription charts. Three out of the eight charts suggested that medication was administered but not signed for and patients' weight was not always record.

Staff stored and managed all medicines and prescribing documents safely. Managers held keys for the controlled drugs (CD) cabinet in accordance with, the Misuse of Drugs Regulations (2001). The contents were checked at each shift change in line with the hospitals policy and outcomes recorded in the CD record log. Records showed checks were completed and correct.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Staff handover sheets included an area to record current medication. Women were issued a medication prescription chart on admission which stayed with them throughout their stay.

Staff learned from safety alerts and incidents to improve practice. Managers reviewed themes around medicine errors and updated staff via emails, at handovers and during staff bulletin updates.

Maternity

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines. Midwives reviewed women's social history at booking and throughout pregnancy. If women disclosed, they misused substances, midwives asked them to produce a urine specimen for toxicology testing. Also, doctors reviewed medication for women on long term pain relief or strong mental health medication.

However, staff told us that pharmacy service were unpredictable because the band 7 pharmacist was only available five days a week between 9 am to 5 pm. There was also a band 5 pharmacy technician who supported maternity staff with medicines management for a few hours a day. Over the weekend hospital wide pharmacy services were only available 10 am to 2 pm with an 'on-call' pharmacist available out of hours.

Incidents

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

Staff knew what incidents to report and how to report them. Staff showed they understood the various types of incidents occurring throughout maternity and knew how to escalate their concerns and how to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff followed trust guidelines on how to identify and report incidents. Staff accessed an electronic reporting system to complete incident reports

The service reported one never event between August 2021 and July 2022. The incident was a retained swab, an investigation identified the root cause of the incident was failure to follow the trust agreed process of reconciling the retained pack during the checking process. Never events are entirely preventable serious incidents (SIs) because national safety recommendations provide strong systemic protective barriers available at a national level.

The service shared learning with their staff about never events that happened elsewhere within the trust.

Staff reported serious incidents clearly and in line with trust policy. The service used an online incident reporting system and updated national Strategic Executive Information System (STEIS) if a serious incident was declared. The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Mortality Reviews Summary Report (PMRT) tool and produced a biannual Summary Report. The total number of perinatal deaths reported to MBRRACE-UK perinatal mortality surveillance from February 2022 – August 2022 was 59. Leaders categorised reporting based on the gestation of the mother. For example, under 23 weeks' gestation to over 37 weeks' gestation.

The most recent PMRT report showed out of the seven cases there were no 'actions planned' recorded for three cases. Those incidents that did have recorded 'actions planned' did not display clear time frames for completion of those actions.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong.

Maternity

Staff received feedback from investigation of incidents, both internal and external to the service. Learning and actions were shared with the staff via interactive boards, emails and on staff message groups. Leaders disseminated quarterly messages amongst staff which included learning from incidents.

Staff met to discuss the feedback and look at improvements to patient care. Leaders met quarterly to discuss improvements and update actions plans and records confirmed this.

There was evidence that changes had been made because of feedback. For example, we saw that several families had asked to take their deceased baby home, but there was not a standard operating procedure (SOP) for this. We saw the service had developed a SOP which was due for approval in September 2022.

The service investigated incidents thoroughly. Women and their families were involved in these investigations. Leaders followed a process for reviewing and rating incidents. All incidents were reviewed by the associate director of midwifery and then allocated to key staff to investigate. Records showed on the 16 August 2022 there were 33 open incidents within obstetrics. None were categorised as moderate to serious.

The service debriefed and supported staff after any serious incident sometimes. Staff told us that debriefing after a serious incident was dependent upon leaders and that debriefs were rare for midwives.

Is the service well-led?

Good 

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

Leadership

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

Barts Health NHS Trust operated a multi-level group leadership model. There was a trust board, and a group chief executive, who oversaw the Barts Health Group. Women and newborn services formed one of nine clinical boards, who provided services at four different locations, with the support of a partnership service and group support service. The group chief nurse was the professional lead for midwifery.

Women and newborn services at Whipps Cross hospital was overseen by a local leadership team. The associate director of midwifery reported to the divisional director, the Whipps Cross Hospital level safety champion, and the chair of the local maternity voices partnership. Local leaders were overseen by the Barts Health non-executive director and the care groups chief nurse.

Leaders from Whipps Cross reported quarterly to the care group board. The leadership team was supported by the hospitals safety champion, the chair of the maternity voices' partnership, the non-executive director safety champion, and the care group chief nurse maternity champion.

Maternity

The non-executive director (NED) worked alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry. Their remit was to bring together a range of internal sources of insight to strengthen board oversight for maternity and neonatal safety by understanding the current outcomes of the service. The NED worked with, had visited the hospital to review services and provided the board with a report of their findings.

The general manager reported to the divisional manager and the obstetric clinical lead reported to the clinical director of obstetrics and gynaecology.

The consultant governance lead, the consultant for labour ward and fetal medicine, the consultant for education and the consultant for fetal monitoring all reported to the clinical director for obstetrics and gynaecology.

The deputy associate director of midwifery managed five maternity matrons, the clinical placement facilitator, the practice development midwife, and the clinical educator reported to the associate director of midwifery. The hospital employed two consultant midwives one for public health and one for intrapartum care. Specialist midwives reported to either the maternity matrons or the education team.

Professional midwifery advocate roles were not established throughout the trust. This was because leadership support was limited with no dedicated time the lead role had not been defined and posts were vacant.

Barts Health Education Academy (BHEA) had implemented a preceptorship foundation in leadership and management course which ran concurrently with the Maternity Programme. Leaders recognised that managers required additional skills in managing a complex service and to support succession planning within the unit.

Vision and Strategy

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

The maternity service was part of woman and newborn services, and their joint vision was 'To deliver world-class maternity and neonatal services to the families of East London and beyond, by providing safe and compassionate care, and putting what matters to families at the centre of everything we do'. Their mission statement was 'To be the best provider of maternity care in the country'.

The current strategy was ending, leaders were in the process of reviewing what was left to do and then incorporating into a forward plan to include local demand, capacity, and national expectations. For example, the completion of the Ockenden report (2022) Early immediate Actions, by working with the local maternity and neonatal system (LMNS) and the local integrated care board (ICB).

The next phase had key principles, maternity was one of five programmes of work that the Acute Provider Collaborative was leading on, on behalf of the Northeast London integrated care board. The LMNS would become the APC Clinical Board for maternity and Neonates to reduce duplication. The membership, scope, and objectives of the LMNS would be reviewed to help it be as effective as possible in the current context and looking ahead.

Maternity

Leaders were planning a maternity framework to set out a strategy and share good practice. The framework included key suggestions and the scope of the strategy as well as including key enablers for example the local integrated care board and Public Health England. Emerging themes identified the changes in the local population and the comparisons of the socioeconomic group of patients being cared for by Barts Health NHS trust.

The trust set up a strategic maternity and neonatal group which aimed to provide a single group-wide strategic forum that provided direction, oversight, and leadership to Barts Health NHS Trust maternity and neonatal services. The group met every other month to review a standing agenda, the national maternity and neonatal reports, maternity dashboard, hospital and updates and screening. Group membership included but was not limited to, the Chief nursing officer, group director of operations, the chief medical director, the director of public health the chair of the women's clinical board and the director of midwifery.

Leaders had recognised the need for change. However, strategies around workforce planning were ineffective as there was limited focus on providing clerical support to reduce the administrative burden on clinical staff. During the factual accuracy process the trust told us that improvements had been made to the provision of support staff. For example, triage now had a permanent administrator to support clinical staff and there was a trial of night- time administrative staff.

Culture

Staff did not always feel respected, supported, and valued due to workload and lack of staff resources. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The most recent staff survey dated 2021, identified areas for improvement for the service. For example, staff did not always feel supported to develop their roles. There were low appraisal rates and not all staff had opportunities to discuss their personal professional development.

Staff had worked excessive hours and had not been remunerated for this. We spoke to numerous staff who were owed up to 100 hours of unpaid work over the year August 2021 to July 2022. When we spoke to managers, they told us they were working on a strategy to correct this. Staff data confirmed only 25% of staff said they had the energy to interact with their family and friends. During the factual accuracy process the trust told us that at the end of September 2022 30% of time owed to staff had been paid back and leaders set a target to pay back all time in lieu by the end of January 2023.

Some staff had raised concerns about bullying and harassment in maternity. The staff survey showed 33% of staff stating they had experienced harassment, bullying or abuse from patients, their relatives, or members of the public.

Staff did not always feel they could speak up about anything that concerned them about the service. Only 50% of staff felt able to raise their concerns, and 17% said they had experienced harassment or bullying from managers.

However, 83% of staff who completed the survey agreed the care of patients was a top priority for the organisation. Also, 83% said they felt a strong personal attachment to their team.

The General Medical Council National Trainee Survey (GMC NTS) 2021 survey completed by medical trainees for obstetrics and gynaecology post speciality results was on par with the national average.

Maternity

Trainee doctors told us that whilst they had found their placement to be interesting and they had learned a lot about caring for high risk patients. They felt burnt out and at times did not feel that their seniors had full oversight into the extent of their workload. We found examples of doctors who were unable to take their annual leave, and days off in lieu of extra days worked. There was a shortfall of five registrars. Managers used internal resources to cover the service which was difficult to source so staff felt pressured to work to help to cover. We were told that annual leave cover was suspended for a three month period. However, during the factual accuracy process the trust told us that during the COVID-19 pandemic staff were asked to suspend their leave.

Doctors told us that they had not been able to gain study leave for their continued professional development due to staff shortages. Also, a junior doctor had been asked to co-ordinate the rota in their own time because there was not enough administrative support.

Women, relatives, and carers knew how to complain or raise concerns. The hospitals divisional safety champion worked with the patient experience midwife to improve care and communication. Women knew how to complain, the service clearly displayed information about how to raise a concern in patient areas. The patient experience specialist midwife supported staff on how to handle complaints. Staff signposted people to the Patient Advice and Liaison Service (PALS). The divisional safety champion worked alongside the non-executive safety champion (NED) to improve care outcomes for people using the service. The NED completed a recent 'walk the patch' to gain insight into the challenges women face when using the service.

The Barts Health NHS Trust was categorised as 'worse than expected' overall in the 2021 CQC Maternity Survey. In comparison to other trusts, for the 21 questions relating to 'labour and birth' Barts Health NHS Trust scored about the same for 12 questions, 'somewhat worse than expected' for two questions, 'worse than expected' for six questions and 'much worse than expected' for 1 question. However, this information was gathered trust wide not broken down into each hospital site.

Managers introduced a maternity mates service for vulnerable and non-English speaking women as result of feedback from patients. The volunteers were able to follow women through pregnancy until the postnatal period, attend appointments and in some cases be present at birth.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations most of the time. However, not all staff were clear about their roles and accountabilities and or had regular opportunities to meet, discuss and learn from the performance of the service.

Staff followed up-to-date policies to plan and deliver care according to evidence-based practice and national guidance most of the time. Staff accessed policies on-line whenever they needed them. However, we found there was no current standard operating procedure for telephone triage or triage. We raised this with managers who advised us that these would be implementing a triage system at the end of September 2022.

There were several forums that fed into the trust's current governance structure, these included the maternity quality and safety group, the maternity board, the maternity operations group and the strategic maternity and neonatal group.

The trust set up a strategic maternity and neonatal group which aimed to provide a single group-wide strategic forum that provided direction, oversight, and leadership to Barts health NHS trust maternity and neonatal services. The group monitored operations, performance, workforce, reviewed organisational structure, and reviewed updates on Ockenden

maternity recommendations. The group met every other month to review a standing agenda, the national maternity and neonatal reports, maternity dashboard, hospital and updates and screening. Group membership included but was not limited to, the chief nursing officer, group director of operations, the chief medical director, the director of public health the chair of the women's clinical board and the director of midwifery.

There was a hospital maternity board, membership included the chief executive officer, director of nursing, medical director, associate director for midwifery, the divisional operations lead and specialist midwives. Meetings were monthly and the maternity hospital board was accountable to the trusts executive board and reported progress to the strategic maternity group. The group had a standing agenda, which included a review of the clinical negligence scheme for trusts (CNST) action plan, a maternity governance/risk report, the maternity dashboard and group updates. The board focused on patient experience and included a patient story.

The practice development midwifery (PDM) team presented a report at the quarterly education faculty and at the maternity improvement board. The PDM's were responsible for facilitating training for midwifery and maternity support workers. The consultant midwife for education had the overarching responsibility for monitoring the training data and compliance.

The consultant midwives were responsible for reviewing training compliance with the CNST minimum data asset on a bi-annual basis. Their report was submitted to the maternity safety assurance and quality committee.

Leaders ran monthly divisional women's quality, safety, and governance meetings. The meetings had a formal agenda and minutes were produced and available to staff throughout the service. The team reviewed serious incident referrals that qualified for a Health Safety Investigation Branch (HSIB) investigation. Minutes from May 2022 confirmed five serious incidents had been referred to HSIB since January 2022. The trust board reviewed outcomes.

Leaders liaised with the local maternity voices partnership (MVP) to make sure they were included in the attendance invites. Leaders produced a report which identified key themes and included an action log which was reviewed so that actions could be closed or added. There was clear evidence within the report that the trust was reviewing its maternity and neonatal governance structure.

Leaders had not introduced a triage standard operating procedure or recognised that staff in triage were using a basic diary to record triage calls without times or recommendations. Also, records showed leaders lost oversight of compliance to Gap Grow national guidance. The impact of lack of guidance meant staff were not always clear about their roles and responsibilities.

Management of risk, issues, and performance

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

Leaders used a maternity dashboard and performance was monitored monthly via the divisional quality, safety, and governance meeting. Records showed the dashboard was being reviewed to reflect national reporting categories. The dashboard did not reflect ethnicity and leaders were working to rectify this.

Maternity

Maternity safety champions met trust wide on a regular basis from all areas of maternity. The team reviewed the perinatal quality surveillance tool, maternity dashboard, continuity of carer and neonatal care and discussion on the maternity safety board.

Barts health were complaint against the 10 Clinical Negligence Scheme for Trusts (CNST) safety standards in 2020. However, in 2022 staffing levels meant they were no longer compliant. During the factual accuracy process the trust told us they were working on achieving all ten standards for year four by February 2023.

Leaders provided an overview of the relaunch of the maternity safety programme via the strategic maternity and neonatal group that included four key workstreams, deteriorating patients including mother and baby which included the introduction of a triage tool and the maternity triage standard operating procedure. Safer procedures aimed to reduce poor care in and around obstetric theatres. Two other work streams were planned for 2023, team working and culture and medicines management.

The women and children's division had a risk register in place, we saw there were 15 current risks to performance and care. We saw risks were discussed in the monthly women and children's board meetings.

Leaders attended the hospital risk management committee which was held monthly and chaired by the hospital's director of nursing. Maternity and gynaecology risks were combined and reported to the hospital risk management committee monthly with a deep dive once a quarter.

Leaders implemented NHS London's 'Operational Pressures Escalation Levels Maternity Framework and Escalation' policy for London. This policy ensured a standardised approach to communicating changes in trusts operational capacity to improve consistency, reduce variation in practice across the region and improve coordination between London maternity services and the London ambulance service (LAS) within the integrated care systems (ICSs) and across the region. It set clear expectations around roles and responsibilities for relevant stakeholders involved in escalation in response to surge pressures at a local, regional, and national level.

The service contributed data to the Clinical Quality Improvement Metrics (CQIMS). As of April 2022, outcomes at the trust were not concerning for any of the measures where data was available.

According to the latest 'National Maternity and Perinatal Audit' rapid quarterly reporting data, October 2020 to September 2021, the percentage of babies born 'Small-for-gestational-age' was 8.1% for the trust overall and the percentage of preterm births 6.9% overall were higher than expected.

The service monitored average induction of labour rates; records showed on average 28% of women had childbirth induced. This was slightly lower than the national average which was 34% in 2021.

Information Management

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

Maternity

The trust ran a combination of electronic and paper-based records systems. We found the electronic patients record systems did not always support staff to maintain a contemporaneous care record because of connectivity or system glitches. It relied on a pressured workforce to enter data and print records in retrospect especially within the community setting. This was identified was a significant risk to the service.

Data quality failed for four of the twelve measures in the NHS Digital maternity dashboard. Data quality in relation to the maternity services dataset has been an issue at the trust over the past few months. However, during the factual accuracy process the trust told us that Bartshealth have completed their digital strategy and submitted this to the LMNS in line with the requirements from CNST/MIS year 4. Progress against this project is monitored through the maternity digital steering group, feeding into the Group Informatics Board, the maternity and neonatal boards, and strategic maternity and neonatal group system.

Leaders told us that the service did not have centralised CTG monitoring because the current IT systems did not support the software. They advised that they were currently exploring their options. However, there was no timeline for completion.

Centralised CTG monitoring was a recommendation and the Ockenden essential immediate actions (2022). Leaders told us that there were issues with the digital patient record communicating with centralised monitoring software. Staff expressed concerns that the trust was not moving fast enough to address this issue as this feature of care would improve oversight and safety.

Records showed there had been numerous data breaches and the trust recognised the challenges of working on different sets of care records. A business plan was in progress to explore systems that functioned will together. For example, a system that could be link to centralised cardiotocograph (CTG) monitoring and digital maternity care records.

Engagement

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

In the 2021 CQC Maternity Survey, Barts Health NHS Trust was categorised as worse than expected overall for engaging with pregnant women and people. Patient feedback included concerns about staff professionalism and gossiping about women whilst working on the service. Also, mothers cited lack of access to pain relief, and lack of mental health support.

Leaders promoted active engagement from the local best beginnings team who supported the maternity voices partnership (MVP). They had recently highlighted concerns about lack of continuity of carer (CoC) for all, although the Ockenden recommendations state that if a trust is short staffed then the CoC model should be postponed.

The MVP attended meetings with maternity managers and were invited to ‘walk the patch’ and speak to women about their experiences of maternity services. The non-executive director liaised with the MVP on a regular basis and visited the hospital to review care and speak to staff and families.

The MVP had provided some positive feedback about midwives support and care in the birth centres and communication from doctors working on the neonatal intensive care unit.

Maternity

The patient experience midwives worked with the MVP chairs review the friends and family test data. This feedback was used to inform quality improvement work which was reported up through the maternity boards at site level.

The hospital had invested in tools and equipment to improve communication with their women whose first language was not English. For example, posters displayed in all areas included information in the most used languages within the area and QR codes so that women and families could access patient information in their own languages. The hospital was piloting an 'Interpreter on Wheels' which was a tablet on wheels that accessed video links to interpreting services so that women could ask questions and understand their assessments and care plans.

The service had responded to the needs of grieving families. The bereavement midwife worked with women and families who had experienced a tragic loss during pregnancy or childbirth. They liaised with third party organisations, arranged cultural ceremonies, and provided parents with momentous to remember their babies. Leaders had identified an area off the labour ward to care for bereaved parents. The facilities provided a home from home setting where parents could seek solace and grieve with support. The area was well maintained, quiet and included the 'cold' cots so that parents who chose could see their babies.

Learning, continuous improvement and innovation

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

Leaders were committed to improvement and innovation. The Whipps Cross Women's and Neonatal Services transformation programme had been funded by Barts charity. The plan was to create an emergency corridor from maternity and the women's centre to the main hospital for urgent need. Provide additional capacity for the expected increase in local birth number which was expected to grow by 33,000 over the next four year, reconfigure clinical space and improve overnight facilities for parents of babies in special care.

The improvement plan proposed to build new research facilities to house five research staff based within the delivery suite and a new dedicated space to discuss clinical trials with women. Leaders wanted Whipps Cross University hospital to be a centre of excellence.

Outstanding practice

We found the following outstanding practice:

- The service collaborated with the local Maternity Voices Partnership to recruit volunteer mothers from different cultural backgrounds to act as 'maternity mates' during pregnancy and childbirth. Staff offered this service to vulnerable and non-English speaking women.
- Interpreter provision in the hospital was tailored to meet the needs of the local populations. The service had introduced various strategies to communicate with women where English was a second language. Leaders introduced posters with QR codes in the most spoken languages so families could access evidence based information. Also, the service was piloting the 'Interpreter on wheels' system, which was a digital tablet that connected to interpreting services and could provide telephone or video links to interpreters at the touch of a button.

Maternity

Areas for improvement

MUSTS

Whipps Cross University hospital maternity service.

- Leaders must ensure that GAP Grow pathways reflect national guidance and that staff were trained to use the pathway and practice is monitored. Regulation 17 (1)(2)(a)

SHOULDS

Whipps Cross University hospital maternity service.

- The service should ensure planned and actual staffing levels are met throughout the service.
- The service should ensure that there is adequate skill mix and that there is always a supernumerary labour ward shift co-ordinator.
- The service should ensure that they make the implementation of centralised cardiotocograph (CTG) monitoring a priority in line with national guidance.
- The service should ensure that they monitor the use of the triage tool once implemented to embed practice.
- The service should ensure that all community midwives are given time to complete their mandatory training.
- The service should ensure that that pharmacy provision for maternity is increased to seven days a week
- Leaders should ensure that all staff receive their annual appraisal.
- The trust should consider introducing newborn RAG rated risk assessments for all babies, which include maternal history, length of labour, mode of delivery, and type of infant feeding. Risk assessments should include a plan of care for the first 24 hours of life for all babies.
- The service should consider recording planned actions and time frames for all Perinatal Mortality Reviews Summary Reports, serious incident reviews and Risk register reports.
- The service should consider monitoring the use of the SBAR tool to make sure that staff complete the assessment and risk aspects of the tool.

Our inspection team

How we carried out the inspection

This focused inspection reviewed the domains of safe and well led using the CQC's established key lines of enquiry (KLOES).

We visited the clinical areas of the labour ward, triage, maternity day assessment unit and the antenatal clinic.

We spoke to 16 staff to better understand what it was like working in the service including senior leaders, midwifes, obstetric staff, practice development midwives, and the patient safety team.

We interviewed leaders to gain insight into the trusts group leadership model and governance of the service.

We reviewed 8 sets of maternity records and 8 prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

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