

Whipps Cross University Hospital

Quality Report

Whipps Cross Road
London
E11 1NR
Tel: 02085395522
Website: www.whippsx.nhs.uk

Date of inspection visit: 15 to 17 October 2019
Date of publication: 17/12/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

We last inspected the maternity service at Whipps Cross Hospital in July 2016. We carried out an unannounced inspection between 15 and 17 October 2019.

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

- The service had taken steps to address the areas of improvement from the previous inspection. During this inspection, the service had dealt with or shown improvement for most of the previously reported areas of improvement.
- The practice development midwife (PDM) organised mandatory training for staff one year in advance and worked in coordination with the shift roster system which meant that staff booked in for mandatory training were not included in shift allocation.
- The trust had clearly defined and embedded processes to keep people safe from abuse and staff demonstrated understanding of safeguarding processes and awareness on how to escalate and report safeguarding concerns.
- The Female Genital Mutilation (FGM) team achieved the first UK court conviction against FGM in February 2019 and was a finalist for a national award for the Lotus clinic.
- All the areas we inspected were visibly clean, tidy, and clutter free. The equipment store rooms were well organised with secure access and we saw evidence that equipment was routinely, and regularly serviced and calibrated.
- Although the maternity service used the modified early obstetric warning score (MEOWS), we found 11 out of 19 records (58%) we reviewed, showed the frequency of observation for MEOWs was missing. We raised this with the trust who responded with a thorough action plan that included daily audits, staffing training and cross site peer reviews. The daily audit results demonstrated improvements had been made.
- Although the service had challenges regarding midwifery staffing, the service ensured there were enough staff with the right qualifications, training and experience to keep women safe from avoidable harm.
- Staff kept detailed records of patients' care and treatment. Most of the records we reviewed were clearly written and dated, with legible signatures and risk assessments had been completed.
- Stock management of medicines was consistent across all maternity areas and medicines that needed to be kept below a certain temperature were stored in locked fridges. Controlled drugs (CD) management across all maternity areas was good.
- Staff were encouraged to raise concerns and to report incidents and near misses. The division effectively shared learning from incidents and good practice with staff through regular meetings.
- The service demonstrated effective internal and external multidisciplinary team (MDT) working to benefit patients. Staff supported each other to provide good care.
- Staff reported a supportive and developmental environment with good learning opportunities to maintain and develop their skills and knowledge.
- The maternity service was taking part in eight research studies and displayed information leaflets regarding the studies for the public to view.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Women told us they felt listened to by health professionals and felt informed and involved in their treatment and plans of care. Staff provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people considering patients' individual needs and preferences. For example, the trust used individualised 'hospital passports' for patients with learning difficulties to help staff understand the patient's likes and dislikes to make them more comfortable.
- The service exceeded the Better Births Strategy's national target for the percentage of women booked into continuity of care (CoC) pathways and personalised care.

Summary of findings

- The maternity service was refurbishing the estates to improve women's experience and kept expecting mums informed ahead of their appointments.
- The service had introduced one-stop clinics; for example, the one-stop twin clinic, to improve patient experience by reducing the volume of appointments and visits to the hospital.
- The service dealt with concerns and complaints appropriately and investigated them in the required time frame and learned lessons from the results, which were shared with all staff.
- Although the divisional team structure had been finalised six weeks prior to the inspection, staff demonstrated awareness of the leadership team and described them as supportive, visible and approachable.
- Senior leads had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions.
- The service actively and openly engaged with women, staff, the public and local organisations to plan and manage services.
- The maternity service was involved in quality improvement programmes which included process mapping and patient experience. For example, the induction of labour (IoL) quality improvement project had revised the outpatient pathway, processed mapped every step of woman's journey through the IOL pathway and included patient experience feedback.

However:

- Although the service had implemented a National safety standard for invasive procedures (NatSSIPs) proforma checklist after two never events in August 2018, further work was required to ensure it was fully embedded.
- Despite the service having numerous alcohol dispensers in all the areas, we observed inconsistent hand hygiene practice amongst all staff groups. However, the service reported zero incidences of hospital-acquired infections and women told us they regularly saw staff using alcohol gel and wash their hands.
- Although we had no medicines management concerns in the service, the service did not have a dedicated pharmacist which meant we had no assurance that medicines reconciliation was taking place in line with trust policy. Senior leads told us this was a historical, trust wide issue which was on the Clinical Support Services (CSS) risk register. However, a pharmacy technician had been in place for the last six months as a bridge to further resource and staff told us the pharmacy technician was supportive and accessible.
- Most women and relatives we spoke with told us the car parking at the hospital presented challenges in reaching appointments on time.
- Although senior leads told us the intranet had information on freedom to speak up guardians, we found staff had inconsistent awareness of them.

Following this inspection, we told the trust that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Contents

| | |
|--|------|
| Summary of this inspection | Page |
| Background to Whipps Cross University Hospital | 6 |
| Our inspection team | 6 |
| How we carried out this inspection | 6 |
| <hr/> | |
| Detailed findings from this inspection | |
| Outstanding practice | 46 |
| Areas for improvement | 46 |
| <hr/> | |

Requires improvement 

Whipps Cross University Hospital

Services we looked at

Maternity

Summary of this inspection

Background to Whipps Cross University Hospital

Whipps Cross University Hospital was founded around the 1900 during World War 1 where the infirmary was used to treat wounded troops. The Hospital also housed London's first hyperbaric unit. A redevelopment of the site planned for 2012 (costing £350m) was abandoned after the withdrawal of one potential PFI partner. Subsequent plans to redevelop the hospital in stages has also been put on hold whilst financial turnaround is in progress. The redevelopment of the A&E Department finished before the 2012 Summer Olympics on the 9 May 2012.

Whipps Cross University Hospital provides a range of general inpatient services with 586 beds, outpatient and day-case services, as well as maternity services and a 24-hour emergency department and urgent care centre. The hospital has various specialist services, including urology, ENT, audiology, cardiology, colorectal surgery, cancer care and acute stroke care.

The hospital serves a diverse local population of more than 350,000 people from Waltham Forest, Redbridge, Epping Forest and further afield. The area has a wide variation in levels of deprivation and health needs, ranging from the most deprived five per cent to amongst the most affluent 30 per cent of electoral wards in England. Waltham Forest comes 15th out of 326 with nearly 48% of the population from deprived minority ethnic communities.

Each site has a Hospital Management Board and a senior leadership team, led by the Chief Executive Officer, with a site Medical Director, Nursing Director and Director of Operations.

Our inspection team






The inspection was overseen by Carolyn Jenkinson, CQC Head of hospital Inspections for London. The inspection team included CQC inspectors, a consultant obstetrician and senior midwife.

How we carried out this inspection

We carried out an unannounced inspection of the maternity service between 15 and 17 October 2019. During our inspection, we visited all clinical areas in the service including the delivery suite, obstetric theatres, clinics, antenatal and postnatal wards and the day assessment unit (Magnolia ward). We spoke with 20 women and their relatives/partners and 59 members of

staff, including midwives, consultants, anaesthetists, senior managers, student midwives, maternity care assistants, discharge coordinators, specialist midwives, housekeepers, security staff, administration staff, matrons and support staff. We observed care and treatment and reviewed a random sample of 34 medical care records and 12 prescription charts.

Maternity

| | |
|------------|--|
| Safe | Good  |
| Effective | Good  |
| Caring | Good  |
| Responsive | Good  |
| Well-led | Good  |

Information about the service

Whipps Cross University Hospital is part of Bart's Health NHS Trust. The maternity services provided at Whipps Cross University Hospital were merged with those provided at the Royal London Hospital and Newham University Hospital in 2012. Bart's Health NHS Trust now provides integrated hospital and community maternity services across all sites.

The maternity service at Whipps Cross University Hospital is part of the Bart's Health NHS Trust Women's and Children's and Division which also provides gynaecology, genito-urinary medicine, neonatal and paediatric services.

Whipps Cross University Hospital has a 44 bed ward (Mulberry ward) of which 20 beds offer antenatal care and 24 beds offer postnatal care; 12 birthing rooms in the delivery suite including two high dependency beds, two obstetric theatres, three recovery beds, triage and one birthing pool; two bereavement suites (Rosebud rooms); a four bed day assessment unit (Magnolia ward) which includes triage, and Lilac birth centre which offers five birthing rooms with ensuite, two birthing pools and three postnatal day beds.

Women can choose to have a home birth supported by community midwives. Four teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The service had also implemented a caseload team in October 2018 who reviewed low risk healthy women. The maternity services also provided specialist services, for example for women with diabetes, those affected by female genital mutilation (FGM) and fetal medicine.

A total of 4296 babies were born at Whipps Cross University Hospital between April 2018 and March 2019. During the same activity period, there were 5056 antenatal bookings and 4047 postnatal bookings.

Are maternity services safe?

Good 

Our rating of safe improved. We rated it as good because:

- Staff received protected time to complete all outstanding mandatory training in the mandatory training week. The PDM organised training for staff one year in advance and worked in coordination with the shift roster system which meant that staff booked in for mandatory training were not included in shift allocation.
- The trust had clearly defined and embedded systems and processes to keep people safe from abuse and staff demonstrated understanding of safeguarding processes and awareness on how to escalate and report safeguarding concerns.
- All the areas we inspected were visibly clean, tidy, and clutter free. Women and relatives we spoke with told us they were satisfied with the cleaning services.
- The equipment store rooms were well organised with secure access and we saw evidence that equipment was routinely, and regularly serviced and calibrated.
- Obstetric theatre staff completed the appropriate safety checks before, during, and after surgery using an adapted version of the World Health Organization (WHO) surgical safety checklist.
- Needle sharps bins were available throughout the wards and the bins we inspected were correctly labelled and none were filled above the maximum fill line.

Maternity

- At our last inspection we found the community midwives were located in a porta cabin which did not have adequate space. On this inspection we found this had improved as the community midwives were now based in Aspen House on the hospital site.
 - The service had a clear transfer in labour pathway for women requiring transfer from the low risk birth setting to the consultant led delivery suite.
 - Although the maternity service used the modified early obstetric warning score (MEOWS), we found 11 out of 19 records (58%) we reviewed, showed the frequency of observation for MEOWs was missing. We raised this with the trust who responded with a thorough action plan that included daily audits, staff training and cross site peer reviews. The daily audit results demonstrated improvements had been made.
 - During the last inspection, the service did not use an acuity tool to monitor activity on the delivery suite. On this inspection, we found this had improved as the service had fully implemented a national acuity tool (Birthrate Plus).
 - Although there was a high vacancy and sickness rate for midwifery staff, the service ensured there were enough nurses with the right qualifications, skills, training and experience to keep women safe from avoidable harm.
 - During our last inspection, the ratio of clinical midwives to births was one midwife to 30 women between April and June 2016 which was worse than the national average of one to 28. On this inspection, we found improvements had been made as the maternity dashboard showed a consistent ratio of one to 28 between April 2019 and September 2019.
 - During the last inspection, the delivery suite had 74 hours of dedicated obstetric consultant cover per week which did not meet the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth recommendation of 98 hours. On this inspection, we found there had been some improvements as the obstetric unit had 80 hours of dedicated obstetric consultant cover per week and was in line with the latest RCOG document Providing Quality Care for Women: Obstetrics and Gynaecology Workforce (2016).
 - We reviewed 34 maternity records and found they were comprehensive, risk assessments had been completed and entries were dated, signed and mostly legible. Although we found records were stored securely, we found some records were not in good condition and had loose paper.
 - Stock management of medicines was consistent across all maternity areas and medicines that needed to be kept below a certain temperature were stored in locked fridges. Controlled drugs (CD) management across all maternity areas was good.
 - Staff were allocated to complete daily checks on drug trolleys, sepsis trolleys, resuscitation trolleys and the postpartum haemorrhage trolley in each maternity area. We checked the trolleys in each area and found that trolleys were organised, and checklists had been completed without omission and the contents were in date.
 - Staff were encouraged to raise concerns and to report incidents and near misses. The division effectively shared learning from incidents and good practice with staff through regular meetings.
 - Staff understood their responsibilities for duty of candour and were able to describe giving feedback in an honest and timely way when things have gone wrong.
- However:
- Although the service had implemented a National safety standard for invasive procedures (NatSSIP) proforma checklist after two never events in August 2018, further work was required to ensure it was fully embedded in the delivery suite.
 - Despite the service having numerous alcohol dispensers in all the areas, we observed inconsistent hand hygiene practice amongst all staff groups. However, the service reported zero incidences of hospital-acquired infections and women told us they regularly saw staff using alcohol gel and wash their hands.
 - Although we had no medicines management concerns in the service, the service did not have a dedicated pharmacist which meant we had no assurance that medicines reconciliation was taking place in line with trust policy. Senior leads told us this was a historical, trust wide issue which was on the Clinical Support Services (CSS) risk register. However, a pharmacy technician had been in place for the last six months as a bridge to further resource and staff told us the pharmacy technician was supportive and accessible.

Maternity

Mandatory training

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

The trust set a target of 85% for completion of all mandatory training courses. These included conflict resolution, equality and diversity, fire safety, infection prevention and control clinical and non-clinical, information governance, moving and handling loads (inanimate loads, low risk patient handling, patient handling practical), preventing radicalisation level three and resuscitation basic life support. Staff told us the training was delivered via e-learning and some modules were face to face.

Although the trust provided the mandatory training compliance rates, the data did not include the number of staff eligible and number of staff trained. Data for October 2019 showed medical staff met the target for eight of the 12 applicable training courses and midwifery staff met the target for seven. The practice development midwife (PDM) monitored mandatory training by keeping a staff database. The PDM organised training for staff by liaising with facilitators one year in advance and worked in coordination with the shift roster system. This meant that staff booked in for mandatory training were not included in shift allocation.

Each month there was a mandatory training week where staff received protected time to complete all outstanding mandatory training. Managers and staff received email reminders and the PDM hand delivered mandatory training packs to staff.

All the trust site's PDMs offered similar mandatory training. This meant some staff such as maternity support workers from Whipps Cross Hospital could attend mandatory training at the other trust sites. The PDM for Whipps Cross Hospital would then provide site specific training.

Although staff told us the moving and handling training did not meet the maternity service's standard, staff demonstrated awareness of using nets and hoists in event of a maternal collapse. The service had worked with the manual handling team to develop a maternity specific manual handling policy which will be released in January 2020. The PDM had planned the training schedule for all midwives between January and

December 2020 to ensure the training is completed. The bespoke training will include management of birth pools including evacuation procedures. The service had revised their birth pool evacuation protocol in October 2019 which detailed the responsibility for the midwife (to call for help and manage airway) and the helpers (to coordinate moving and handling).

The trust has replaced the practical obstetric multi professionals training (PROMPT) with the multidisciplinary obstetric team training (MOTT). Midwives and medical staff were trained in undertaking cardiotocography (CTG) where the fetal heart rate was monitored as part of MOTT. The CTG training was led by an obstetric consultant followed by an assessment after the session. Agency staff also attended CTG training and were provided with the necessary information during their orientation. The delivery suite coordinators had access to training compliance data for agency staff to ensure that staff who were not compliant with the appropriate training (including mandatory training), were not booked onto any shifts. Trust data between June 2018 and June 2019 showed 99% and 100% compliance in midwives and medical staff respectively.

Staff received sepsis training during MOTT. Between June 2018 and June 2019, data showed 99% compliance for midwives and 100% for medical staff (against trust target of 90%).

Safeguarding

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

Safeguarding training was incorporated into staff's mandatory training and included Safeguarding Adults (level one and two) and Safeguarding Children (level one to three). The trust set a target of 85% for completion of safeguarding training. Data for October 2019 showed both medical and midwifery staff met the target for four of the five applicable safeguarding training courses except for the safeguarding children level 3 module. The trust told us a few newly qualified doctors had started which had impacted the training compliance data. However, all staff have had dates identified to complete this training. The trust informed us that the safeguarding children level 3 training (face to face) training for

Maternity

midwifery staff in August 2019 had been cancelled but had been rearranged. Staff told us the safeguarding adult's team were providing training on safeguarding adults level three at the end of October 2019.

Staff had access to the trust's adult and children's safeguarding policies and procedures via the staff intranet. We found the policies included information on individual responsibilities and the process to follow for reporting and escalating concerns about a patient's welfare. The service incorporated information about female genital mutilation (FGM) in their procedures. All the staff members we spoke with were able to identify abuse and demonstrated consistent awareness of FGM.

Each trust site had a named doctor, named nurse and named midwife. The named midwives for safeguarding across the trust's sites had quarterly meetings where alerts and learning from cases was shared.

Each trust site had a safeguarding team for adults and children who were available Monday to Friday 9 am to 5pm. For evenings and weekends, there was an on call system for the safeguarding team. We observed that the safeguarding team's contact details were displayed near the reception desk or on staff notice boards in all maternity areas.

The site's safeguarding team had monthly safeguarding team meeting for adults, children and maternity. The team provided reports for Board, monitored training and reviewed incidents, themes and serious case reviews. The designated nurse chaired the health and economy meeting and provided one to one supervision for the named midwife. The team had close working links with the local clinical commissioning group (CCG) and local authorities. Between October 2018 and September 2019, the maternity service made 384 safeguarding referrals to the local authority. However, staff told us communication with some of the local authorities was challenging at times as each one worked differently.

The FGM service (Lotus clinic) was provided in partnership with the local CCG and local authorities. The monthly clinic provided an antenatal pregnancy clinic for women who were survivors of FGM. Referrals could be made by the midwife, GP or women could self-refer. The team achieved the first UK court conviction against FGM and had won a national award.

There was also a monthly walk in clinic for survivors of FGM who may require cervical screening. The clinic offered cervical screening, advice and support for any FGM related concern with an FGM specialist, gynaecologist and a Somalian interpreter. The clinic was provided in partnership with the local borough, local CCG and Barts Health NHS Trust and the maternity teams contributed to the National FGM database.

The Ruby team ran antenatal and postnatal clinics for vulnerable women and referrals could be made by any department including community midwives. The criteria for referral included domestic violence disclosure, learning disability, mental health, substance misuse, modern slavery, FGM and forced marriage. Where an expecting mother had safeguarding concerns noted in the antenatal appointments, the Ruby team would take over the patient's care. Safeguarding alerts flagged on the electronic record and all safeguarding cases were discussed in the weekly referral meetings. The team managed 'did not attends' (DNAs) by calling women in the first instance. If there was no answer, the team carried out a home visit. The team worked closely with GPs and would be notified of missed GP appointments and DNAs with the community midwives. The team had been recognised for their work and won a Barts Hero Award.

The vulnerable team included two band 6 and two band 7 midwives and although there was a referral criteria, women could be referred to the team at any point. One of the band 7 midwives was a specialist in perinatal mental health. The team carried out risk assessments and the updated the electronic records. The team carried out home visits for women who DNA and informed the GP accordingly. Where any major concerns were identified, women would be asked to come into the hospital.

Women living with learning disabilities had capacity assessments in antenatal clinics. The trust used learning disability passports and had a dedicated link nurse for learning disability.

The trust was part of the child protection information system (CP-IS) which allowed sharing information with the local authorities who had signed up to the scheme. Staff told us that most local authorities had signed up. Shared information included child protection plans and who to contact in the relevant local authority. The scheme also flagged children if they had unscheduled visits to the emergency departments. The trust was also

Maternity

part of an FGM information system called FGM-IS which was applied at birth for female babies. If the baby appeared at the emergency department in any hospital, this would flag up on the NHS spine. Reports from CP-IS and FGM-IS would feed into NHS England and the monthly integrated safeguarding assurance committee (ISAC) meetings attended by the lead nurse and director of midwifery.

Baby tagging was reviewed twice daily and would be reported as an incident if a baby was found without a tag. The PDM carried out a simulation exercise on baby tagging annually. Although the service had baby tagging on the risk register, the risk was related to stock levels of the tag as it was only available from one supplier nationally. The service had mitigated the risk by securing three months' supply of stock which was regularly monitored. In event of no stock, the service would activate the continuity plan which involved increasing the level of security presence and surveillance in maternity areas

Women we spoke with were aware of how to access chaperones and told us staff offered the service to them.

Cleanliness, infection control and hygiene

The trust's infection prevention and control (IPC) team were available Monday to Friday 9am to 5pm with access to the on call microbiologist during out of hours and weekends. Staff told us they could contact the IPC team easily but would usually contact the IPC midwife.

The trust had a service level agreement with an external contractor to provide cleaning services. We saw the domestic service provision was displayed in all areas. IPC audits for April 2019 showed the compliance rates were: 71% for antenatal clinic, 93% for delivery suite, 87% for day assessment unit and 89% for Mulberry ward. The common theme identified was high dust levels either on the floor, equipment or work surfaces. The head of midwifery met with the external contractor and arranged for all maternity areas to have a deep clean and sign off by the matron in each area. Senior leads encouraged staff to raise an incident form where concerns were identified about cleaning standards. Staff told us domestic staff visited each area daily. Women we spoke with told us they observed staff cleaning frequently.

During our inspection, we reviewed patient areas across the wards including utility rooms and treatment rooms.

All areas we checked were visibly clean with no clutter in the corridors despite the ongoing refurbishment. The service used 'I am clean' stickers to identify equipment that had been cleaned and was ready for use. All the equipment and stickers we sampled were clean and the date was recorded.

We found curtains were in date and the cleaning schedules for equipment were up to date and fully completed. For example, we saw staff regularly completed checks on birthing rooms and pools in the Lilac birthing centre. We inspected various items of equipment such as baby scales, infusion pumps and ultrasound machines and chairs and found a good level of cleanliness. We saw the hygiene code checklist was completed daily on the delivery suite and included equipment such as monitors, resuscitation equipment, cardiotocography (CTG) machines.

During the last inspection we found there was a reliance on haemacue estimates rather than the blood gas machine for haemoglobin blood tests for women experiencing a postpartum haemorrhage. On this inspection, we found this had improved as the service had a fetal blood gas machine and laboratory facility was available for bloods. This was in line with national recommendations (Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). Although the blood gas machine had been safety tested, we found the machine had visible blood splatters. We raised this with staff and saw it was addressed immediately.

Bathrooms including showers and toilets were cleaned and checked three times a day. We checked a sample of bathrooms/toilets in each area and saw the checklist had been completed fully and found the areas to be visibly clean. However, some of the women we spoke with in the antenatal clinic told us the toilets were not always clean and often ran out of toilet paper. At the time of the inspection, there were two toilets in the antenatal clinic area and staff told us that the maintenance team were slow to respond for example, in event of a blocked toilet. However, as part of the redevelopment, there were plans to have additional toilets in the antenatal clinic.

Maternity

Waste management and removal, including those for contaminated and hazardous waste was in line with national standards. There were waste disposal bins in appropriate locations on the ward and those we checked were not overfull.

The maternity service provided staff with sufficient access to personal protective equipment (PPE) which included sterile gloves in different sizes and aprons. The service had numerous alcohol dispensers in all the areas and we observed staff request all visitors to use them. Handwashing facilities with posters for cleaning your hands were seen throughout the service. Although most staff we observed were compliant with the trust's policy and were bare below the elbow (BBE), we found some staff did not adhere to infection control related aspects of the uniform policy. For example, we saw a couple of staff members with large earrings and necklaces.

Although we saw notice boards dedicated to IPC which included information such as cleaning protocols and sepsis, we found the IPC audit results were not always updated or displayed. For example, on the delivery suite, although the area was visibly clean, the notice board did not display any IPC audit results.

The trust provided the weekly hand hygiene audits for each maternity area between March and October 2019. The trust told us the audits were not carried out during certain weeks as the lead midwife for IPC had left. Although we found there were no results for three weeks in July, two weeks in August and three weeks in September; the remaining results showed that compliance was consistently 80% or more in all the maternity areas in the reporting period.

During the inspection, we observed inconsistent hand hygiene practice amongst all staff groups. We raised this with the senior leadership team and were told that the IPC performance of maternity has deteriorated recently due to a change in the IPC link nurse role. The service had recently appointed a replacement midwife who started their role at the end of September 2019.

We reviewed the results for the first week of October which showed that the antenatal clinic, delivery suite, day assessment unit (Magnolia ward) and Mulberry ward achieved 90% compliance. Results for week two of October (before the inspection) showed 80% compliance in the antenatal clinic and delivery suite, 90% in Magnolia

ward and 100% in Mulberry ward. The trust was committed in achieving consistent compliance and had tasked the infection control team to complete weekly hand hygiene audits and had included hand hygiene as a standing agenda item at the quality and safety meetings until the service was compliant. Women told us they regularly saw staff using alcohol gel and wash their hands.

Between October 2018 and October 2019, Mulberry ward and Magnolia ward reported zero incidences of hospital-acquired methicillin-resistant *Staphylococcus aureus* (MRSA), *clostridium difficile* (C. diff) and methicillin-susceptible *Staphylococcus aureus* (MSSA). The data provided did not include the delivery suite due to its short stay nature.

Isolation procedures were in place for women with infections by using the side rooms. Staff told us that in event of a patient being isolated, the side room would be marked clearly to alert staff and visitors with instructions of the precautions to take prior to entering the side room.

The service used safety bundles such as for urinary catheter and vascular access which was in line with National Institute of Health and Care Excellence (NICE) Infection prevention and control quality statements 4 and 5.

Environment and equipment

The maternity service was undergoing major refurbishments during the time of the inspection. The service displayed signs throughout the service to inform visitors about the redevelopment work and staff informed women ahead of appointments. Staff told us the development was due to finish in May 2020.

The entrance to the maternity unit had CCTV in operation and entry to the reception area was restricted. Security staff were present at the entrance 24 hours a day and monitored visitors entering the maternity unit. Security staff told us they were given lists for all maternity areas, so they could check visitors on arrival prior to granting them access. Visitors were asked to sign in and out at the security desk. Both triage in the delivery suite and Mulberry ward had CCTV monitors showing the entrance area.

After visitors went through to the reception area, they had access to lifts or stairs to get to Lilac birth centre and the

Maternity

day assessment unit (Magnolia ward) on the first floor and Mulberry ward on the second floor. The delivery suite was located on the ground floor. Each area had restricted access and we observed visitors requesting entry via the buzzer on the intercom.

At our last inspection we found the community midwives were located in a porta cabin which did not have adequate space. On this inspection we found this had improved as the community midwives were now based in Aspen House on the hospital site.

The medical engineering team were responsible for equipment maintenance and staff told us they reported faults online. The service kept a log for equipment maintenance which was categorised based on risk and its ability to cause harm in event of failure or insufficient compliance to regulatory standards. High risk equipment was prioritised and serviced six monthly or annually and medium/low risk equipment was serviced annually or longer. Data for October 2019 showed that most of the high risk equipment was in date for servicing and the hospital site overall was 90% compliant with the in house key performance indicator (KPI).

During the inspection, we saw evidence that equipment was routinely, and regularly serviced and calibrated. The equipment store rooms were well organised and clean with secure access. We checked various items of equipment such as defibrillators, blood pressure monitors, infusion pump, syringe driver, hoist, ultrasound machine and found they had been safety tested and were all within service date. Weighing scales used by community midwives were calibrated twice a year by an external contractor and we saw evidence this was up to date.

Needle sharps bins were available throughout the wards and within the medication preparation area. The bins we inspected were correctly labelled and none were filled above the maximum fill line.

Fire extinguishers were stored securely and in date throughout the service. Staff told us live fire drills took place every three years.

Staff in the antenatal clinic told us the ultrasound machine was on the risk register as the quality of the

image was poor. Senior leads told us that two of four machines were replaced in April 2018 and the remaining machine was on the 2019/2020 trust replacement equipment scheme.

During the inspection we observed the generator test taking place. The service displayed signs with the times of the test to make both staff and visitors aware.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and removed or minimised risks.

In line with Better Births guidance, midwives asked women about their baby's movements at each antenatal contact to reduce the risk of still birth. Staff advised women to contact the day assessment unit or the 24 hours triage in the delivery suite if they had any concerns about their baby's movement. The escalation procedure included a care pathway specific by trimester. Staff told us women were offered ultrasounds for even one incidence of reduced fetal movement. Written information regarding this was also given to women in the 'Your Pregnancy Care at Whipps Cross Hospital' booklet. This was in line with national guidance (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016).

Women with more complicated pregnancies were offered a comprehensive range of specialist antenatal services and clinics. The clinics were provided by a multidisciplinary team which included specialist midwives, obstetricians, anaesthetists, medical doctors, paediatricians, health workers and dieticians. Examples of clinics offered included diabetic/endocrine clinic, fetal medicine team, multiple pregnancy clinic, mental health clinic, and vaginal birth after caesarean (VBAC) clinic.

The maternity service provided a weekly specialist genitourinary clinic (perineal clinic) within the general outpatient unit (Area A). The clinic was provided by an obstetrics and gynaecology consultant and registrar and referrals were either from the GP or internally from other consultants.

The maternity service used the fetal growth assessment protocol (GAP) charts to help identify babies who were not growing as well as expected. The service had improved the compliance rate with GAP/GROW to greater

Maternity

than 90% with detection rates of small fetuses which was in line with national standards. This meant that women could be referred for further scans and plans made for their pregnancy.

There was a clear transfer in labour pathway for women requiring transfer from the low risk birth setting to the consultant led delivery suite. Women requiring management of complications were cared for in one of the high dependency rooms on the delivery suite. We also observed the briefing that took place between the elective and emergency teams which included the consultant anaesthetist covering delivery suite who was able to provide information about the predicted emergency workload.

Basic life support was part of the mandatory training programme. The trust told us midwives and obstetric staff did not routinely attend advance life support (ALS) or intermediate life support (ILS) training. The maternity service had 13 midwives who had completed the university based high dependency training and all midwives attended the annual in-service training days which covered high dependency unit (HDU) scenarios such as eclampsia, haemorrhage and sepsis. During the inspection, we saw the emergency buzzers were working and connected to the delivery suite.

The maternity service used an adapted version of the World Health Organisation (WHO) surgical safety checklist which was referred to as the National safety standards for invasive procedures (NatSSIPs) checklist. This was in accordance with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist, January 2009). The checklist was used for women having a c-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. The trust provided audit results for September 2019 which showed 100% compliance for completion of the NatSSIPs checklist in obstetric theatres.

We observed the daily safety huddle where there was representation from each maternity area. Attendees included the 'hot week' consultant, clinical and non-clinical staff, bereavement midwife, governance midwife, ward managers for each area, safeguarding midwife, community midwives, neonatal sister, senior clinical educator, sonographer, clinic manager and the senior leadership team. The focus for the huddle was

safety and staffing. Staff also received updates from the senior leads on areas such as recruitment. We observed discussions around activity in all areas and saw that any staffing hotspots were escalated to agency. Mulberry ward also had an additional huddle each afternoon to discuss staffing, incidents and message of the week.

SBAR (situation, background, assessment and recommendation) is a structured method for communicating critical information that requires immediate attention and action, contributing to effective escalation and increased patient safety. Although senior leads told us SBAR was used in handovers, we did not observe this consistently in the handovers we attended. Staff told us they used the SBAR handover tool when escalating or handing over difficult cases.

NHS England collects data on nine key performance indicators (KPIs) for screening. These KPIs included the number of women: tested for HIV, sickle cell and thalassaemia; referred for Hepatitis B specialist assessment; completed laboratory request forms for Down's syndrome screening; tested by 10 weeks gestation; the number of laboratory requests with completed Family Origin Questionnaire and avoidable repeats for new born blood spot test and the number of babies having a newborn and infant physical examination (NIPE).

Trust data between April and June 2019 showed the service either met or were close to meeting the acceptable threshold for most of the KPIs. The service had 11 midwives who were qualified to perform the newborn and infant physical examination (NIPE) checks with four additional places funded for training in January 2020.

The service completed venous thromboembolism (VTE) risk assessments (used to determine a patient's risk of developing a blood clot), in line with national recommendations. VTE audit performance between September 2018 and September 2019 showed that the delivery suite achieved 100% consistently each month. The average performance for Lilac birthing centre and Mulberry ward was 99.7% and 99.5% respectively. In the 34 patients' notes reviewed, we found staff completed VTE risk assessments.

Maternity

New born babies were checked for jaundice and women received information on the testing process in the 'Your Pregnancy Care at Whipps Cross Hospital' booklet. Serum bilirubin levels (SBR) were completed by the neonatal sister or doctors.

The maternity service had sepsis trolleys which contained all the required equipment to speed up the response to managing patients with sepsis. The trolleys were checked daily by midwifery staff and included a book to record all women started on the sepsis pathway to ensure follow up was completed. We saw evidence of sepsis protocols on display for staff in the delivery suite and Mulberry ward. The intranet had information on sepsis screening and treatment for staff to access.

Staff told us that senior leads did weekly ward rounds completing spot checks on cleanliness and equipment and provided a feedback session after. The senior leads also used this as an opportunity to triangulate the risk register for the service.

Staff recorded cardiotocography's (CTG) on the electronic system every hour with a system of 'fresh eyes' in place every two hours to check the interpretation was correct. This was in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016). We saw evidence of good CTG traces in documentation. The delivery suite coordinator completed the daily foetal surveillance proforma to check CTG interpretation and this was checked by the practice development midwife (PDM) weekly. We saw evidence of using 'fresh eyes' in a case discussed at the weekly risk meeting we observed.

The trust had lone working arrangements for community midwives which included work mobiles, access to diaries, panic alarms and the team went out in pairs at night. For home births, community midwives would inform the delivery suite when arrived at the women's homes and when they were leaving.

The maternity service used the modified early obstetric warning score (MEOWS), designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. However, 11 out of 19 records (58%) we reviewed, showed the

frequency of observation for MEOWs was missing. We analysed the themes for serious incidents in the last 12 months and found no evidence that deterioration of patient was a contributing factor.

Transitional care babies were managed by the neonatal sister and the nursery nurses completed the neonatal early warning scores (NEWs). Staff told us that staffing issues could lead to delays in observations, but no more than 30 minutes delays was accepted, and transitional care babies remained with their mothers. During our inspection we reviewed three observations for babies and found non-compliance with the four hour frequency.

Although we did not identify any deteriorating women or babies during the inspection as a result of the frequency not being documented, we raised this with the senior team as improvements were required in reviewing the completion of MEOWs and NEWs. The trust responded with a thorough action plan that included daily audits on MEOWs and NEWs for a minimum of four weeks until consistent compliance was achieved. The plan was for the audit to be completed by ward managers from other areas to eliminate bias; for example, the delivery suite completed audits on Mulberry ward and vice versa. Audit results would be shared at handovers, department meetings and the divisional risk and governance meeting.

The daily audits commenced on the afternoon of day two of the inspection and we observed the ward manager complete the audit on day three. The audit measured compliance on completing all the necessary information in MEOWs and NEWs. Day one results for Mulberry ward showed MEOWS compliance was 62% in antenatal notes and 50% in postnatal notes. Emerging themes included lack of compliance in documenting height, weight, BMI, booking blood pressure recordings and lack of postnatal physiological monitoring plans. Results showed that compliance with NEWs completion was 91%. Day two showed improved compliance for MEOWS with 75% in antenatal notes and 78% in postnatal notes. The compliance of NEWs on day two was 83%. Audit results at the end of week two for Mulberry ward showed MEOWS compliance was 84% in antenatal notes, 95% in postnatal notes and NEWs compliance was 100%. Results at the end of week three showed 100% compliance for MEOWS (antenatal and postnatal) and NEWs completion.

Day one results for delivery suite showed that although documentation such as height, weight and BMI was

Maternity

completed, only 1 out of 13 (7.6%) maternal notes included frequency of observations. However, the compliance for NEWs completion was 100%. The service responded immediately by escalating this to the two band 7s working the night shift to ensure the handover included discussion around the importance of completing MEOws and NEWs in full. The service also sent an urgent message to all permanent staff using the social media application to reinforce the importance of recording the frequency of observations. The same message was written on the handover board and shared as the message of the week for 15 October 2019. Day two showed significantly improved compliance for MEOws with 78% and NEWs remained at 100%. Audit results at the end of week two for the delivery suite showed MEOws compliance was 90% and NEWs compliance was 100%. Results at the end of week three showed 100% compliance for MEOws and NEWs completion.

The trust started MEOws and NEWs refresher training for staff on 18 October 2019 and were planning to include refreshers at the regular mandatory training as a sustainable plan. The PDM had also drafted a checklist for the transfer of women in 24 hours which included a handover around MEOws and a discharge checklist. Incident forms will be completed when information is not completed when transferring women between departments. Trust wide actions included starting peer reviews of MEOws and NEWs audits across all maternity sites on a quarterly basis to provide assurance to the trust. The cross site peer review would be presented at maternity board. The director of midwifery completed a peer review of MEOws and NEWs in Mulberry ward on 24 October 2019. We reviewed the report which acknowledged that although improvements had been made since the daily audits started, further improvements were required to achieve consistency, and these were detailed in the recommendations for antenatal and postnatal care.

Midwifery and nurse staffing

Although there was a high vacancy and sickness rate for midwifery staff, the service ensured there were enough nurses with the right qualifications, skills, training and experience to keep women safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

During our last inspection, the ratio of clinical midwives to births was one midwife to 30 women between April and June 2016 which was worse than the national average of one to 28. On this inspection, we found improvements had been made as the maternity dashboard showed a consistent ratio of one to 28 between April 2019 and September 2019. Senior leads told us the funded establishment for midwife to birth ratio was one to 26.

Between July 2018 and June 2019, the annual vacancy rate for midwives was 12% (trust target not provided). However, during the inspection, senior leads told us the service had 25 WTE band 6 vacancies which was included on the risk register (and equated to 19% of midwifery workforce based on the funded establishment of one to 26). Senior leads told us the recruitment of band 6 staff was a national challenge and the impact of Brexit had not helped. The service used bank and agency staff for unfilled shifts and senior leads told us the regular midwifery staff also did bank shifts. The head of midwifery would approve the use of agency 24/48 hours in advance. Between October 2018 and September 2019, 20.8% of shifts were filled by bank, 4.5% were filled by agency and 2.8% were unfilled. Staff completed red flag incidents when staffing levels impacted patient care.

Although the trust carried out rolling recruitment monthly and had a recruitment lead for midwifery staff between band 2 and band 6, senior leads told us the calibre of candidates was an issue. However, the trust had appointed 12 preceptors and three band 6 midwives in September 2019. The service had developed and was in the process of releasing a promotional video to use on social media to attract more applicants by making the public aware of the hospital's journey and share updates around the ongoing refurbishment works.

During the last inspection, the service did not use an acuity tool to monitor activity on the delivery suite. On this inspection, we found this had improved as the service had fully implemented a national acuity tool (Birthrate Plus). The delivery suite used the acuity tool every four hours to monitor activity and complexity of patient care, whilst Lilac birth centre used the acuity tool every two hours.

Maternity

The dedicated theatre team provided a seven day service which meant they were not reliant on the delivery suite staff. The recovery beds and high dependency unit (HDU) beds were covered by midwives and one HDU nurse.

The day assessment unit (Magnolia ward) was staffed with two midwives, one midwife assistant Monday to Friday 9am to 5pm with access to the medical team. On the weekend, midwifery staffing included one midwife and one midwife assistant.

Lilac birth centre had two registered midwives and one maternity assistant on the long day shift (8am to 8.30pm) and on the night shift (8pm to 8am).

The delivery suite notice board indicated the early and late shift had 12 midwives and two maternity assistants and the night shift had 11 midwives and two maternity assistants. The 24 hour triage unit was managed by one midwife during the day shift and one midwife at night with support from the medical team on the delivery suite where needed.

During our last inspection, the delivery suite coordinator was not supernumerary. On this inspection, although this had improved as the delivery suite coordinator was supernumerary, if there was a staff shortage, the coordinator would then undertake a clinical role.

The Mulberry ward notice board showed the staffing levels for each shift. The early shift and late shifts each had five midwives and two maternity assistants. The night shift had four midwives and two maternity assistants. The ward manager told us that one nursery nurse and one neonatal nurse also worked on night shifts on the ward and two discharge coordinators covered the ward during the day. The early shift was 8am to 4pm, late shift was 12.30pm to 8pm and the long day shift was 8am to 8.30pm.

Paediatric clinics took place on Mulberry ward with a paediatric lead for high risk women (Monday to Friday) and midwives provided the weekend cover for low risk women. The receptionist manned the reception desk Monday to Friday and midwives provided cover in the evenings and on weekends. On the inspection, we saw each cubicle had the names of the responsible midwife and maternity care assistant for the public and staff to view.

The antenatal clinic had three midwives with support from three midwife assistants Monday to Friday 9am to 5pm. Staff told us that despite the fluctuations in sickness rates, clinics were never cancelled. The service had one midwife sonographer and three sonographers available Monday to Saturday.

The midwife in charge completed the daily rosters for staff breaks which we saw on display on Mulberry ward during the inspection. The roster included staff name, shift times and duration of break. The ward manager told us some staff had to be encouraged to take their breaks.

Between September 2018 and August 2019, the annual sickness rate for midwives was 3.3% (trust target not provided). Senior leads told us that long term sickness was a challenge as some staff had major health problems. The service had an on call rota for managers (band 8a and above) 24 hours a day, seven days a week. The manager on call covered issues such as serious incidents and staffing.

The trust used an electronic roster system which ensured that staff members who had a short or long term sickness period, were not able to book bank shifts until after an interim period. The interim period for a long term sickness was two weeks with clearance from occupational health and included a phased return. Agency staff returning from sick leave would report to the head of midwifery. Staff told us that human resources (HR) attended stage one meetings and provided support. Staff received their rotas eight weeks in advance.

The community midwifery team had three vacancies and staff absence was due to maternity leave. The current caseload for community midwives was 1: 36 which was in line with recommendations from Birthrate Plus (2018). The trust told us that bookings and births had declined for 2018-2019 which had decreased the caseload for each community midwife

The service had one bereavement midwife available Monday to Friday 8am to 4pm.

The immunisation team included three registered nurses and one midwife between Monday to Friday and on weekends, there was one registered nurse for the Bacillus Calmette Guerin (BCG) clinic.

Medical staffing

Maternity

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.

In May 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Between September 2018 and August 2019, the annual sickness rate for medical staff was 2.3%. Between July 2018 and June 2019, the annual vacancy rate was 18.4% and between October 2018 and September 2019, medical staff turnover was 11.9%. The trust target was not provided for sickness, vacancy and turnover rates.

During the daytime shift (8am to 5pm), an obstetric specialist registrar (SpR) and senior house officer (SHO) supported the consultant obstetrician on duty. In addition, the 'hot week' consultant covered the delivery suite Monday to Friday 8am to 5pm and did not have any other clinical commitments during this time. Medical cover from 5pm to 8am included a consultant on call (on site till 10pm and then remotely from home), SpR and SHO with support from the senior SpR for gynaecology and obstetrics, an anaesthetic SpR and the on-call consultant anaesthetist if needed.

On weekends, the consultant was onsite 8am to 1pm and then provided remote cover from home until 8am. The trust told us that all the consultants lived within the statutory distance to the hospital in cases of emergency. Junior doctors told us they could easily contact the on-call consultant obstetrician who would come on site to support if needed. Junior doctors found the workload manageable and reported good working links with midwives and discharge coordinators.

An obstetric consultant (separate from the delivery suite) was responsible for postnatal and gynaecology ward rounds Monday to Friday. The ward manager and matron for Mulberry ward attended the doctors huddle at 5pm to discuss activity and staffing.

The day assessment unit (Magnolia ward) was open 8am to 8pm. The medical team consisted of a consultant, SpR and SHO and midwives told us they checked in with the unit in the morning and were easily contactable throughout the day. The midwives would complete the

assessments and escalate to the medical team as needed. Between 5pm and 8pm, the midwives could access the medical team covering the delivery suite when needed.

During the last inspection, the delivery suite had 74 hours of dedicated obstetric consultant cover per week which did not meet the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth recommendation of 98 hours. On this inspection, we found there had been some improvements as the obstetric unit had 80 hours of dedicated obstetric consultant cover per week. However, the trust informed us the obstetric workforce deployment was in line with the latest RCOG document Providing Quality Care for Women: Obstetrics and Gynaecology Workforce (2016). The 2016 document stated, 'All units should have consultant delivery suite presence during working hours Monday to Friday, with the intention to extend this to every day of the week' and the guidance no longer specified hours but emphasised on the quality of care.

We saw details of the clinical team on duty displayed on the notice board in the delivery suite. The team included the matron, consultant, discharge coordinator, obstetric specialist registrar (SpR), senior house officer (SHO) and anaesthetist.

There were two obstetric theatres staffed by a dedicated theatre team who provided 24-hour cover. The team included two theatre nurses, senior registrar, operating department practitioner (ODP), anaesthetist and a team of scrub nurses. The unit was supported by a level two neonatal unit on site. The service had a dedicated anaesthetist for elective lists and if the theatres were needed out of hours, the ODP and staff from the main hospital would be called. Therefore, the obstetric theatres were therefore not reliant on the delivery suite staff.

Records

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

The maternity service used a mixture of paper and electronic records. Antenatal outpatients were paper based and inpatients services use electronic records.

Maternity

Although anaesthetic follow up entries were made in a separate database, staff told us some anaesthetists documented within the electronic record if an intervention had been made.

Women carried their own handheld pregnancy records, which they were advised to bring to each antenatal appointment and any occasion when they attended the hospital. Antenatal screening results and ultrasound scan findings were included in the handheld records. This was in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, last updated January 2017; NICE Antenatal care: QS22 (3)).

Although some agency staff did not have access to the electronic system, the service mitigated any risks by ensuring agency staff could easily access the system via designated colleagues such as discharge coordinators or band 7 midwifery staff. Agency staff told us they were also present with doctors during discussions for the women's care. Agency staff recorded their notes on paper which permanent staff later copied onto the electronic systems which added to workload and could potentially lead to delays in patient care. A further mitigation was to assign low risk women to agency staff. Agency staff who had block bookings had access to the electronic system and had received appropriate training. We reviewed documentation by agency staff and found records were completed fully with all the necessary risk assessments.

Between April 2018 and December 2018, 29 audits of electronic and paper records took place on various dates. Results showed 100% compliance with the following outcomes: allergies and adverse reactions, risk factors identified, primary care contact, patient identifiers on each page, contact details for patient, ethnicity and named team identified. Results showed 97% compliance with recording contact details for the next of kin, 90% compliance with place of birth been discussed and documented and 98% had VTE risk assessments completed.

We reviewed 34 maternity records for women at different stages of the maternity pathway and found these were completed in line with national standards (NMC The Code: Professional standards and behaviour for nurses and midwives, 2015). Records were comprehensive, risk assessments had been completed and entries were dated, signed and mostly legible.

Although we found records were stored securely, we found some records were not in good condition and had loose paper. However, all patients' records were locked away in the cupboards or in lockable trolleys, no records were seen unattended. We found computer terminals were locked when not in use.

Discharge and care summaries were sent to the GP, community midwives, health visitors and other professionals to ensure continuity of care in the community. The summary included information about the woman's pregnancy, labour and postnatal care, medications prescribed, treatment and procedures, follow-up plan and action, and any ongoing risks and/or follow-up care needed. A copy of the discharge summary was also given to the patient. The personal child health record (also known as the 'red book') was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

Medicines

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

Access to treatment rooms was restricted either via keypad access or swiping a key card. We found all the cupboards were locked. Oxygen and Entonox cylinders were appropriately stored in the storage areas within the service and all the cylinders we checked were in date. We found the IV fluids were stored securely and neatly.

Stock management was consistent across all maternity areas. On Mulberry ward we saw the monthly checklist for expiry of drugs had been completed by midwives without omission between January and September 2019. We randomly checked five drugs and found the medicines were in date. The ward manager ordered stock twice a week and staff told us that non-stock items could be ordered via the pharmacy communication book. In the antenatal clinic, we randomly checked a sample of single use items and found one single use pack out of date. We raised this with staff who addressed it immediately and replaced the item. The delivery suite used 'short expiry date' stickers and 'discard after opening' stickers for stock management.

Controlled drugs (CD) management across all maternity areas was good. CDs were stored in a lockable,

Maternity

wall-mounted units and the keys were kept with the midwife in charge. CD balance checks were completed daily by two midwives and the CD book was neatly and accurately completed, and there were no missing entries or signatures. Results for the CD audits in quarter two (Q2) and quarter three (Q3) 2019/2020 showed improvements in compliance rates for each maternity area. Mulberry ward scored 67% in Q2 and 81% in Q3; Magnolia ward scored 67% in Q2 and 95% in Q3 and the delivery suite scored 68% in Q2 to 82% in Q3. During our inspection, we checked a sample of CDs in each maternity area and found quantities matched the CD register and the medicines were in date.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. All the maternity areas had air conditioning in the treatment rooms and we found the ambient and fridge temperatures were checked daily. Fridges displayed the protocol on what to do if the fridge temperature was out of range. The blood fridge was centrally controlled by blood bank and samples were scanned using codes. The BCG clinic stored vaccines in a dedicated drug fridge and we saw evidence that the fridge temperature checklist was completed without any omissions.

Staff in each maternity area were allocated to check all the different trolleys daily. These included drug trolleys, sepsis trolleys and the postpartum haemorrhage trolley. The neonatal team checked the neonatal trolleys. We checked the trolleys in each area and found that trolleys were organised, and checklists had been completed without omission and the contents were in date. Staff told us the PDM carried out spot checks of the trolleys.

Emergency medicines were stored on the resuscitation trolley throughout the maternity service. We checked the trolley in each area and found all the trolleys were adequately stocked with all items on the checklist present and in date. We saw evidence of daily checklists being completed without omissions. For example, on Mulberry ward, we found no omissions in the resuscitation trolley checklist between August and October 2019. We checked the hypoglycaemia kits (Hypo box) in the delivery suite and found all the checks had been completed and the contents were in date.

Staff demonstrated awareness of how to report medicines incidents via the electronic reporting system and told us they received information on medication

incidents via email. The PDM carried out reflective exercises with staff involved in medication incidents. Staff told us that following an incident involving peppermint oil, staff on medication rounds wore a red apron which said “please do not disturb on meds round” to prevent them being interrupted.

We found ‘to take away’ (TTA) medicines were kept securely in locked cupboards and staff kept a record where women had to return to collect TTAs. The discharge coordinator checked the contact details as part of the discharge process. Staff called women to remind them to collect their TTAs when they were ready to collect. However, staff told us they would often try some women several times and never get an answer. Although staff recorded each attempted contact, incidences where no contact was made presented challenges for staff to close the TTA loop and the process took up a lot of administration time. We raised this with senior leads who told us they were exploring options to overcome this challenge and would seek advice from the trust’s chief pharmacist.

We reviewed 12 prescription administration charts and found they were all signed, dated and legible. We found that patients’ allergy status was documented appropriately which was essential to avoid serious medication errors from being made. Antibiotics were prescribed and reviewed regularly and ‘when required’ (PRN) medicines for pain and nausea were included. However, we found no evidence that the drug charts had been reviewed by a pharmacist.

The maternity service did not have a dedicated pharmacist and staff told us they had access to a pharmacy technician Monday to Friday 9am to 5pm. Although we had no medicines management concerns in the service, we had no assurance that medicines reconciliation was taking place within 24 hours in line with trust policy. Medicines reconciliation is the process of identifying the most accurate list of all medicines that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medicines obtained from a patient, or GP. We did not observe pharmacy presence on ward rounds, MDT rounds or during the discharge process. Staff told us the maternity service had never had a dedicated pharmacist.

Maternity

We raised this with the senior leads who told us the gaps in pharmacy provision were known and related to the historical staffing establishment across the site and recruitment challenges. The pharmacy staffing gaps were on the risk register for Clinical Support Services (CSS) and were repeatedly escalated by the site medicines safety and management committee. Senior leads told us this was a trust wide issue as maternity services across all the trust sites had similar resourcing gaps. CSS and the site leadership team were working on a business case to correct pharmacy staffing funding, while mitigating the effects of the gaps by aligning pharmacy resource to areas of greatest need, prioritising duties of pharmacists, and encouraging collaborative working between pharmacy and clinical teams. The pharmacy structure was changing across the trust with a head of pharmacy in each site who would report to the trust's chief pharmacist. The pharmacy technician post in maternity had been in place for the last six months as a bridge to further resource. All staff we spoke with told us the pharmacy technician was supportive and accessible.

The pharmacy technician completed quarterly audits which included the storage of medicines, fridge medicines, controlled drugs, drugs trolley, sepsis trolley, resuscitation trolleys, up to date information relating to medicines/pharmacy available on the wards and review of five random drug charts. Trust data for October 2019 (quarter three) showed the compliance rates were 89% for Mulberry ward, 97% for day assessment unit (Magnolia) and 94% for the delivery suite.

Between October 2018 and October 2019, the maternity service reported 42 medicine incidents. The most common theme identified was prescribing the incorrect prescription (24%) and learning was shared through various forums such as quality and safety meetings, ward meetings, safety huddles, message of the week and the medicines management committee.

Patient group directions (PGDs) allow some registered health professionals (such as midwives) to give specified medicines to a predefined group of patients without them having to see a doctor. The service used PGDs, for example, midwives could provide the first dose of a prescription only pain medication. We saw one PGD which was in development and found it was comprehensive as it included indication, inclusion and exclusion criteria, cautions, action to take if the patient

declines or doesn't meet criteria, drug details such as name, strength, dosage, frequency and administration, when to refer, documentation, which staff are suitable to use PGD (i.e. only staff employed by trust) and the decision algorithm. PGDs were authorised by the lead doctor, lead midwife, lead pharmacist and chair of PGD committee.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported at Whipps Cross University Hospital within maternity between September 2018 and August 2019. (Source: Strategic Executive Information System (STEIS))

There were two never events within 24 hours in August 2018 within the maternity service involving a retained foreign object. We reviewed the 72 hours reports and the root cause analysis (RCA) reports for both never events and the RCA from a recent serious incident. The 72 hour reports included detailed descriptions of the incidents, actions taken in immediate response to the incident, arrangements for staff support, actions agreed and evidence that duty of candour requirements were met. The RCA reports included a detailed account of events in chronological order, root causes, lessons learnt, recommendations and shared learning. The action plans included the expected outcome, response/action needed, agreed key performance indicator (KPI), delivery date and responsible owner. A traffic light system was used to flag progress update (RAG rating).

Further to the never events, the service had since implemented National safety standards for invasive procedures (NatSSIP) proforma which required signatures by two separate people. Although the recent audit showed improved compliance in proforma completion from 35% in August 2019 to 85% in September 2019, we

Maternity

found inconsistent compliance during the inspection. For example, we found that whilst the completion of the proforma was fully embedded in obstetric theatres and the birthing centre, the delivery suite had inconsistent compliance. We also found that some staff were unable to link the proforma to the previous never events.

We raised this with the divisional team who acknowledged that whilst improvements in compliance had been made, further improvements were still required to fully embed the process. Senior leads told us the proforma had been modified three times and was now in its final form. The audit had also been amended to ensure all three points of entry were captured in data collection. There was a trust-wide meeting on day three of the inspection to revise the governance structure and metrics and this was attended by the Whipps Cross Medical Director and the Whipps Cross NatSSIPs lead. The revised governance structure would bring about the ward-to-board changes required to ensure that each member of staff knew and complied with their responsibilities. Whilst the revised structure was being embedded, the service would include NatSSIPs reviews in the clinical Friday audit programme. The service would continue auditing the completion of the proforma until the target of 100% was reached consistently.

Between 14 October 2018 and 15 October 2019, the maternity service reported 1031 incidents. From these, one resulted in severe harm, 984 (95%) no harm, 38 (3.6%) low harm, 8 (0.7%) moderate harm and no deaths. The most common identified themes included obstetric haemorrhage (25%), staff shortage (17%), unanticipated admission to neonatal unit (14%) and bookings related (13%).

Incidents were reported on the hospital electronic system. Staff were aware of their responsibilities for reporting incidents and able to explain how this was done. The trust provided staff with RCA training either via an external company who provided a one day training session and the patient safety team also provided monthly RCA training.

Most staff members told us they received individual feedback for incidents they had reported. Some agency staff did not have access to the electronic system. This meant they relied on other staff to either provide access to the electronic system or to report the incident on their behalf. In the case of the latter, the agency staff would not

get feedback directly but would rely on colleagues to feed back. We raised access to the electronic system for agency staff with the senior team, please refer to the information management subheading for further information.

Key messages and lessons learnt from incidents were discussed with staff during handovers, ward meetings, quality and safety meetings, message of the week, safety huddles and in the serious incident risk management and assurance panel (SIRMAP) meetings. The weekly SIRMAP meetings were chaired by the clinical director for safety and included discussion on risk and serious incidents. We reviewed one set of minutes for September 2019 and two sets for October 2019 and found the learning from incidents was shared with a narrative on key events, factors contributing to care and areas for improvement. The minutes included a list of attendees and an action log with identified leads, due date and date completed.

The audit midwife shared the Healthcare Safety Investigation Branch (HSIB) reports across the maternity team. From April 2018, the HSIB became responsible for all patient safety investigations of maternity incidents occurring in the NHS which met the criteria for the Each Baby Counts programme. Each Baby Counts is the Royal College of Obstetricians and Gynaecologists (RCOG) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. For these incidents HSIB's investigation replaces the local investigation and the trust remains responsible for Duty of Candour and actioning any safety recommendations made following these investigations.

There were weekly morbidity and mortality meetings for the maternity service and trust wide. The meeting was chaired by the consultant obstetrician and attended by midwives, trainees and consultants. Although there were no formal minutes captured, an attendance log was kept which also included topic discussed with short summary and learning points identified. Perinatal morbidity and mortality meetings took place every two weeks with the special care baby unit (SCBU) and these meetings included plans for bereavement.

We attended the weekly divisional risk meeting and observed discussions around a recent neonatal death on the weekend prior to inspection. We found the discussion included details around the incident, immediate shared

Maternity

learning identified, duty of candour, support for staff and arrangements for a debrief. Staff told us they received debrief support from their managers after difficult incidents. The staff area/multidisciplinary team (MDT) room in delivery suite had a live notice board which included morbidity and mortality learning and sharing of incidents.

Staff were aware of their responsibilities in relation to the duty of candour. All staff we spoke with were aware of the principles of openness and accountability when things go wrong. Senior leads told us that mandatory training included duty of candour.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection took place one day each month – a suggested date for data collection was given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Although we saw the Safety Thermometer data displayed in all the different maternity areas for staff and visitors to see, we found some boards had not been updated. For example, in the delivery suite, data for pressure ulcers and acquired infections was left unfilled for September 2019. We requested the safety thermometer data for all the maternity areas for the last three months, but the trust could not provide this due to error submission. The trust told us the service was working on improving their data submission processes.

The Maternity Safety Thermometer is a measurement tool for improvement that focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. The tool allows maternity teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced 'harm free' care. Although the maternity service did not display the maternity safety thermometer, the trust provided data for July and August 2019. Data showed that the proportion of patients experiencing harm free care had improved from 70% in

July to 75% in August (against the national average of 74.8%). The proportion of women who had a maternal infection had also improved from 7.5% in July to 5% in August (against the national average of 5%).

Are maternity services effective?

Good 

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

- There was effective multidisciplinary team (MDT) working both internally and externally to support patients' health and wellbeing. There was effective dialogue and joint working within the service and with other services in the hospital, such as maternity and paediatric emergency department.
- The service participated in local and national audits; for example, the National Neonatal Audit Programme (NNAP). Results showed outcomes were better than expected or within expected range.
- The maternity service used care bundles, a group of evidence-based interventions, which improved the quality of care and patient outcomes when used collectively.
- There were appropriate processes in place to ensure that patients' nutritional needs and pain relief needs were met.
- Senior leaders of the service had a good understanding of local population needs and were planning service delivery to meet those needs.
- During the last inspection, the trust did not offer an immunisation programme. On this inspection, we found this had improved as the service provided a Bacillus Calmette Guerin (BCG) vaccine clinic and additional funding had been secured to expand the immunisation clinic to provide flu and whooping cough clinics by December 2019.
- The service monitored the effectiveness of care and treatment and used the findings to make improvements for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support.

Maternity

- Staff reported a supportive and developmental environment with good learning opportunities to maintain and develop their skills and knowledge.
- The maternity service was taking part in eight research studies and displayed information leaflets regarding the studies for the public to view.

However:

- Although the service provided care and treatment based on national guidance and evidence-based practice, we found several guidelines despite being updated had not been published on the trust intranet. This was a trust wide issue and was included on the risk register. The trust had recruited a dedicated staff member to address this and the service was mitigating this by printing paper copies of the updated guidelines for staff to use.
- The service had not been able to collect audit results for the average time waited for an epidural after requesting due to challenges faced with the electronic system and how anaesthetic data was collected. The service had been working with the business intelligence unit (BIU) and Royal London Hospital to harmonise the electronic database and was due to start data collection at the end of October 2019.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

All guidelines for the maternity service could be found on the intranet and were based on the evidence-based guidelines provided by the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). Examples included Continuous Cardiotocography (CTG) and Fetal Blood Sampling (FBS) Guidance (March 2021), Hepatitis B screening in pregnancy and prophylaxis for babies of hepatitis B mothers (September 2020) and Emergency Care and Resuscitation Plan (October 2020). Patient information leaflets such as Perineal Tears Following Birth also referenced RCOG guidance.

However, we found several guidelines which were out of date. Examples included Medicines Management Policy (June 2019), Consent to Examination and Treatment (May 2019), and Medicines reconciliation (September 2018). We

also found that where guidelines had been updated, they had not been cross referenced appropriately. For example, the safeguarding guidelines for children had been updated in May 2019 but the safeguarding children's training policy was out of date (January 2014) and referred to the 2012 version of the safeguarding children's policy.

We raised this with senior leads who told us this was a trust wide issue and it was included in the risk register. Several guidelines despite being updated had not been uploaded onto the trust intranet. The trust had recruited a dedicated staff member to address this. Although the service was mitigating this by printing paper copies of the updated guidelines, senior leads recognised the need to ensure the files containing the paper copies were kept up to date.

The diabetes specialist midwifery service included two midwives who were supported by a consultant endocrinologist, an obstetric consultant and their respective teams. Women with pre-existing or gestational diabetes (GDM) were referred for a glucose tolerance test. This was in line with national guidance (NICE Diabetes in pregnancy: management from preconception to the postnatal period, last updated August 2015). The first appointment for a woman with GDM was with a diabetic midwife and dietician. The dietician provided dietary advice and the midwife taught women how to use the blood monitoring machine and how to record the readings. Women were followed up in one week to review BM readings and midwives provided contact numbers should the women have any concerns.

The vaginal birth after caesarean (VBAC) team included a consultant midwife, one band 7 senior midwife and one band 6 experience midwife. The team offered a main clinic which provided a regular VBAC appointment for women with one previous caesarean and the consultant midwife provided weekly fast track clinics for urgent VBAC appointments for women with two or more previous caesareans. The consultant midwife told us the format of the VBAC clinic was due to change in November 2019 following the success of two pilots. Previously women were reviewed by going through a rigorous checklist which meant women had 10 minutes to discuss any issues. The new format would include a group education session with a midwife and four or five expecting mothers. Women would then have a one to one session

Maternity

with the midwife to share any confidential matters for 15 minutes. This meant women received more education and had an opportunity to form networks with other expecting mothers and had dedicated time to raise confidential concerns.

The service also offered a birth option clinic which was an antenatal consultant service for parents with complex care planning needs. The service ran weekly and had an inclusion criteria. Although the waiting time for the main clinic was four weeks, the service offered fast track clinics for urgent both option appointments where women were seen within one week. This provided women with the opportunity to discuss birth options in their current pregnancy (NICE QS32: statement 1).

There was a dedicated breech clinic to streamline the management of breech presentation at term. This was in line with national guidelines (RCOG External Cephalic Version and Reducing the Incidence of Term Breech Presentation (No 20a) March 2017 and Management of Breech Presentation (No 20b), March 2017).

The audit midwife coordinated monthly audit meetings and we saw the evidence log for the audit meeting in July 2019 which had 40 attendees.

The maternity service used care bundles, a group of evidence-based interventions, which improved the quality of care and patient outcomes when used collectively. For example, the perihealth care bundle for perineal trauma in childbirth.

The service was in the process of implementing a patient group direction (PGD) to allow midwives to offer aspirin to high risk women to reduce the risk of preeclampsia in line with national guidance (NICE QS35: statement 2, last updated July 2019). This was in response to some women not being prescribed aspirin in a timely manner. Midwives would assess women at the booking appointment and provide the first supply where appropriate.

In March 2019, the service had achieved stage 2 accreditation in the UNICEF baby friendly scheme which meant 95% of maternity staff (including midwives and maternity support workers, neonatal nurses and theatre staff) were all trained and assessed in supporting mothers and babies with breastfeeding, fully informed

choice to bottle feed and supporting close relationship building. The maternity service was audited by UNICEF baby friendly team on a regular basis as part of the process towards achieving Stage 3 in 2020.

The maternity service was taking part in eight research studies and displayed information leaflets regarding the studies for the public to view. For example, the service displayed the ACROBAT study leaflet which included information on the study, current treatment standards, why the study was being run, details on study design, the impact on the women, the risks, importance of the study and contact details should there be any questions. The study investigated the treatment for postpartum haemorrhage (a condition where there is heavy bleeding in pregnant women after child birth). The ACROBAT study was in collaboration with the other hospital sites in the trust, Barts Charity, a local university and another local NHS hospital.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

The service had a booklet called 'Your Pregnancy Care at Whipps Cross Hospital' which included information on healthy eating and drinking, food to avoid in pregnancy, vitamins in pregnancy, and after birth information on vitamin K for the baby.

We saw posters on the baby friendly initiatives maternity standards displayed in on Mulberry ward. These included the points to check with new mums such as what is responsive feeding, how to feed, what is a good feed and nappy count. The poster included information for support groups for example, the national breastfeeding helpline and staff told us women would be referred to the infant feed coordinator where needed. Staff worked collaboratively with the infant feeding coordinator when specialist input was required in management plans. On the day assessment unit, we saw a poster advertising an 8 week confident and wellbeing programme which covered the signs in infant feeding and moving forward.

Mulberry ward had offered a daily breastfeeding drop in clinic which took place in the maternity lounge on the ward. Between April 2019 and September 2019, the

Maternity

maternity dashboard showed the breastfeeding initiation rate was 74.6% (against trust target 75%) and breastfeeding rate at discharge from hospital was 80% (against trust target 75%).

The high body mass index (BMI) clinic was a specialist's antenatal service for women with a BMI of 35 or more which may pose a substantial risk in pregnancy. The clinic was staffed by a consultant obstetrician, an anaesthetist and a midwife. Each woman was assessed and assigned a plan of care.

The elective and emergency caesarean sections leaflet included what to eat and drink before the operation and enhancing recovery. Women were given advice on fasting before their elective caesarean section. This was in line with national guidance (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

Although the maternity service did not use Malnutrition Universal Screening Tool (MUST), women were routinely weighed at the start of their antenatal care to determine their body mass index (BMI) and this was recorded in the hand held maternity notes. Women with a BMI of greater than 35 were reviewed by a consultant obstetrician, the anaesthetic clinic and received a glucose tolerance test. Women with very low BMIs and/or possible eating disorders had individualised care plans and were referred to the perinatal mental health team where needed. Individual women could also be referred to the dietician for dietary support.

However, women experiencing hyperemesis gravidarum (HG) were admitted to the gynaecology ward and received a MUST assessment. HG is a pregnancy complication that is characterized by severe nausea, vomiting, weight loss, and possibly dehydration. Feeling faint may also occur.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff provided pregnant women with evidence-based information about the availability and provision of different types of analgesia, in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

Women were given options and allowed to choose their methods of pain relief as part of their birth plan. Most women we spoke with told us they had received good pain relief and were asked regularly if they needed analgesia. Staff referred women to doctors if they did not feel well enough for discharge. Although the trust had a pain team, midwifery staff told us they rarely used them as they could easily access the doctors including in the evenings and weekends.

The delivery suite had one birthing pool and the Lilac birth centre had two birthing pools for pain relief and water birth. Between October 2018 and September 2019, 121 out of 621 (19.5%) women had water births in Lilac birth centre and 6 out of 3536 (0.2%) had water births in the delivery suite.

Pharmacological methods of pain relief were readily available and included 'gas and air', opioids (such as pethidine and oral diamorphine) and epidural anaesthesia. There was good anaesthetist cover which was available 24-hours a day, seven days a week. The birth centre offered breathing and relaxation techniques, mobilisation and Entonox (a mixture of nitrous oxide and air) as part of the pain relief.

National guidelines recommend that the time from which a woman requests an epidural to the time they are ready to receive one should not normally exceed 30 minutes; this period should only exceed one hour in exceptional circumstances (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013). We requested audit results for the average time women waited for an epidural after requesting and the trust told us there was no audit data in the past 12 months. The service had faced challenges with their electronic database and how the anaesthetic data was collected. The service had been working with the business intelligence unit (BIU) and Royal London Hospital to harmonise the electronic database to collect this data. Data collection was due to start at the end of October 2019 with the aim to achieve anaesthetist

Maternity

attendance within 30 minutes (or 60 if busy in theatres). On the delivery suite, there were two anaesthetists who shared the workload with the consultant and obstetric specialist registrar (SpR) to meet the standard.

We saw that regular analgesia was prescribed for post-operative women, including opioids and non-steroidal anti-inflammatory drugs (NSAIDs). Women who had undergone surgery such as caesarean section, were given pain relief for use at home when they were discharged. The postnatal care pregnancy booklet included information on 'advice following a caesarean delivery' which covered regular pain relief.

However, we observed one woman who was in pain at the time of discharge and although pain medication was provided, we did not see a pain assessment being completed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

In April 2019, Barts Health received an outlier letter from the CQC highlighting a higher than average (across the UK) Emergency Caesarean rate at Whipps Cross Hospital and Newham University Hospital. The performance during this period for Whipps Cross was 18%. The service randomly selected 40 sets of notes and carried out a review for all cases coded as Emergency Caesarean Section between October 2017 and September 2018. The case mix included weekday/weekend deliveries, daytime/overnight and a selection of category 1/2/3 Emergency caesarean sections. The reviewed records showed that most of the caesarean sections were performed in women who were high risk at the onset of labour/presentation to hospital and a consultant obstetrician was involved in the decision making in most of the cases. The service identified themes and put in place actions to address each theme.

The newborn blood spot screening (often call the heel prick test) was carried out when the baby was ideally five days old. Tiny spots of blood are collected from a heel prick and tested for several serious but rare conditions which can be treated more effectively if detected early. The neonatal sister carried out the newborn blood spot on day five for all transitional care babies.

The service re-audited Induction of Labour (IoL) in June 2019 having changed the outpatient pathway and induction drug in November 2018. Every step of woman's journey through the IoL pathway was processed mapped. The induction drug was changed from Prostaglandin (a gel that cannot be removed) to Propess (a tampon containing slow release medicine which can be removed). Women came into the hospital to have Propess inserted and then went home, except for high risk women who were admitted and had IoL as an inpatient. Results showed that between November 2018 and June 2019, IoL had been carried out in 26% of births and 26 women had not been booked on the electronic system. However, results also showed improved compliance with the pathway with a reduction in admission time. Feedback from women identified areas of concern such as communication and staffing on the delivery suite. Although improvements had been seen in most areas audited, an action plan had been developed with named leads for areas that required improvement and a re-audit was planned for November 2019.

The hospital measured key performance indicators required by commissioners, such as screening and safeguarding. The service participated in local and national audits; for example, the National Neonatal Audit Programme (NNAP), National Maternity and Perinatal Audit Programme (NMPAP). Results showed outcomes were better than expected or within expected range for most of the metrics. The trust contributed data to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK). MBRRACE is a national programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. Although stillbirths and neonatal deaths are investigated by Healthcare Safety Investigation Branch (HSIB) with the trust agreeing appropriate actions, the service had a bereavement midwife who was involved in the MBRRACE audit, Each Baby Counts programme and the monthly audits on the perinatal mortality review tool (PMRT).

Competent staff

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

Maternity

All obstetrics and gynaecology trainees attended a three day induction programme which covered: trust wide aspects such as mandatory training and values; cross site training which included CTG, skills and drills, simulation training and human factors; and a local site specific induction and safeguarding supervision. Trainees were not expected to work on call until they had completed the induction programme. Each trainee was assigned a clinical supervisor and educational supervisor who met with the trainee within first 2 weeks of joining.

The maternity service had one practice development midwife (PDM), one clinical educator and one clinical practice facilitator who were available Monday to Friday. The clinical practice facilitator ensured students had a mentor of suitable ability and experience.

The clinical educator supported newly qualified midwives with education training needs and practical elements of the preceptor programme. Newly qualified midwives rotated across all the maternity areas and the placement had been increased by four to six weeks to include a placement with ambulances to get a complete patient experience. Midwives signed off competencies following observational assessments. The corporate preceptorship was delivered centrally at Royal London Hospital with other staff groups such as allied health professionals. There were 12 sessions with six classroom and six action learning sessions.

The PDM supported midwives with their revalidations, organised mandatory training, provided staff with a debrief/reflective discussion after serious incident/difficult case, attended the weekly MDT meeting for case learning and provided training to doctors during their induction. Staff returning after a long absence had to complete mandatory training to update them on any changes and the PDM also provided one to one support where needed.

All newly qualified midwifery staff received a preceptorship handbook which covered roles and responsibilities, the process, details of the management team and specialist midwives, learning outcomes and competencies for specific areas. All staff were required to complete statutory and mandatory training appropriate to their role. Midwifery staff also completed the

multidisciplinary obstetric team training (MOTT) which included maternity specific topics. We spoke with new preceptor midwives who provided positive feedback about the training and told us staff were welcoming.

New midwives were supernumerary for four weeks and maternity support workers for three weeks. The local induction programme included information on competencies, contact details for all six professional midwifery advocates (PMA) and preceptorship details. PMAs supported staff with their wellbeing and provided opportunities for reflection.

The service had a checklist for agency induction which included orientation to documentation and risk assessments (electronic and paper records), how to access blood results and safeguarding flags on the electronic system. Agency staff were offered regular IT training but completed their mandatory training in obstetric emergencies through the agency. Bank staff could access the trust's mandatory training for free and there was a small fee for agency staff. Senior leads told us agency staff could not be booked if their training was not up to date.

There was a trust wide practice development midwife (PDM) dedicated to developing midwifery care assistants and maternity support workers. The first cohort were due to start their midwifery apprenticeships in January 2020. However, the application process had identified that some staff did not meet the university criteria with regards to their level of Maths and English. The PDM supported these individuals with their Maths and English so that they could meet the criteria in the next round of applications. Staff who were not successful on this cohort would be prioritised on the next cohort.

Staff received an appraisal once a year. The midwifery appraisals were completed manually due to previous issues with electronic documentation. The service had been given the deadline of 30 November 2019 for all appraisals to be uploaded centrally. Data showed the current appraisal rates for midwifery care assistants in each maternity area as: community (100%), antenatal clinic (100%), Lilac birth centre (100%), day assessment unit (100%), delivery suite (88%) and Mulberry ward (86%). Data showed the current appraisal rates for midwifery staff as: day assessment unit (100%), antenatal clinic (100%), community (77%), delivery suite (68%),

Maternity

Lilac birth centre (82%) and Mulberry ward (70%). The trust told us the remaining appraisals had been scheduled to meet the target deadline. All staff we spoke with told us they had had their appraisal.

The service provided multidisciplinary obstetric simulation training (MOST), team obstetric and anaesthesia simulation training (TOAST) and carried out live drills. These sessions covered all obstetric emergencies in different clinical areas such as: cord prolapse, eclampsia, post-partum haemorrhage, shoulder dystocia, sepsis and baby tag drill.

For example, Mulberry ward had a cord prolapse live drill on July 2018 which identified the reason for delay in response was that it took staff time to collate all the required equipment. The service then developed prolapse bags which had a checklist to ensure all the necessary items were present and staff checked the contents daily. The effectiveness of the prolapse bag was tested in August 2018 and staff demonstrated better response times. The PDM tested staff about the location of the bags as part of the mandatory training session.

Staff were given protected time to attend cross site training and received invitations via emails. Staff told us the last training session was a CTG masterclass which took place at Newham University Hospital.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

The maternity service multidisciplinary team (MDT) worked together to improve women's care and reach the optimum outcome. Doctors, midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women's care and treatment.

We saw evidence of close working relationships between midwives and medical staff internally and externally. Midwifery staff told us the medical staff were approachable and supportive whilst doctors said that input from midwifery staff was invaluable. This was mirrored across all staff grades including support staff,

matrons and ward managers. Community midwives told us they felt part of the hospital and had good working relationships with GPs and health visitors external to the trust.

We observed an MDT handover and saw there was discussion around overnight issues, ward status and prioritisation of cases. There were 20 attendees which included consultant obstetricians, consultant anaesthetists, registrars for obstetrics and anaesthetics, senior house officers (SHO), midwives, and maternity assistants. The maternity service also had weekly MDT meetings where cases were presented, and learning was shared.

We observed a ward round attended by the consultant and registrar for obstetrics, SHO for obstetrics, midwife and anaesthetist. Each case was reviewed, women were prioritised and potential cases for theatres and high risk women were identified. We saw evidence of similar discussions for each case to consider the best approach for each woman when we observed a briefing between the obstetrician, anaesthetist and on-call consultant.

Perinatal mental health liaison meetings took place monthly with the local NHS foundation trust to share information on women who were due to deliver their baby at the hospital. Attendees included health visitors, named midwife, social worker, safeguarding advisor for children and adults, family nurse partnership, clinical specialist from mental health and the perinatal psychiatric consultant. Records were kept on the electronic system and attempts were made to input every maternity attendance on the electronic system to prevent women repeating themselves.

Delivery suite forums were held every month and attendees included the head of midwifery, matrons, consultant obstetricians, operating department practitioners, and staff from the Lilac birth centre and triage. We reviewed the minutes for September and October 2019 and found there was consistency in the format and structure of these meetings. The meetings discussed exception reports, the ongoing building works, developments, relationships between departments, and incidents.

Seven-day services

Most key services were available seven days a week to support timely care.

Maternity

The maternity service had access to seven-day medical cover. Between 8am to 5pm, an obstetric specialist registrar (SpR) and senior house officer (SHO) supported the consultant obstetrician on duty in addition to the 'hot week' consultant (who covered the delivery suite Monday to Friday 8am to 5pm). Medical cover from 5pm to 8am for all maternity areas included a consultant on call (on site till 10pm and then remotely from home), SpR and SHO with support from the senior SPR for gynaecology and obstetrics, an anaesthetic SpR and the on-call consultant anaesthetist if needed.

Anaesthetic cover was available for emergencies on delivery suite and the maternity service 24 hours a day, seven days a week. This was in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

There were two obstetric theatres staffed by a dedicated theatre team who provided 24-hour cover. Between Monday to Sunday (8am to 8.30pm) the team included two scrub nurses, one health care assistant, one operating department practitioner (ODP), consultant anaesthetist and anaesthetic registrar. Night cover included two scrub nurses, one ODP and one anaesthetic registrar.

The day assessment unit (Magnolia ward) was open from 8am to 8pm, seven days a week. Out of these hours, women could self-refer to the triage unit on the delivery suite.

The triage unit on the delivery suite was available to women 24 hours a day, seven days a week. Women could telephone for advice or present to the unit if they had any concerns or health issues.

The community midwifery service provided first booking appointments, antenatal appointments and postnatal appointments for women in the local borough, Monday to Sunday 9am to 5pm. The booking clinics were provided on site in the community midwifery facilities at Whipps Cross Hospital. On-call arrangements were in place 24 hours a day, seven days a week to facilitate the home birth service and provide any other advice or care to women at home, as needed.

Midwifery support workers (MSW) provided the new born screening checks on Saturday and Sunday (9am to 5pm) for all low risk babies for women who lived in the local boroughs.

The Imaging department provided an outpatient and inpatient service Monday to Friday 9am to 5pm as well as an emergency service for x-ray, ultrasound and computerized tomography (CT) scans 24 hours a day, seven days a week.

The antenatal clinic had two scanning slots on Saturday and women could access the phlebotomy service Monday to Saturday. Where demand required, additional sessions were provided in the evening between 5pm and 8pm.

The vulnerable team provided cover seven days a week with five registered midwives (RM) and one registered nurse (RN) Monday to Friday, one RM and one RN on Saturday and one RN on Sunday.

The case loading midwifery team provided antenatal, intrapartum and postnatal care for low risk women, 24 hours a day, seven days a week. The case loading team had a caseload of up to 36 patients and the team consisted of six midwives with one vacancy.

The dietetic service was available Monday to Friday 9am to 5pm with no weekend cover. The service could be accessed via referral for maternity inpatients only.

The onsite pharmacy was open Monday to Friday 9am to 5pm. Between 5pm and 8pm, staff could access the on call pharmacist on site. After 8pm, the on call service moved centrally to Royal London Hospital (RLH). The pharmacy was open 10am to 2pm on Saturday and Sundays and support was available between 2pm and 4pm from the on call pharmacist on site. After 4pm, on call service moved centrally to RLH. Staff told us the service had access to the emergency drug cupboards via the site manager.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

During the first pregnancy appointment, midwives discussed maintaining a healthy pregnancy by providing advice on how to eat healthily, stop smoking and alcohol consumption.

Maternity

The 'Your Pregnancy Care at Whipps Cross Hospital' booklet included information on healthy eating and drinking, vitamins in pregnancy, keeping fit, alcohol, drugs, smoking and after birth information on vitamin K for the baby.

The postnatal care pregnancy booklet included information on healthy lifestyle, contraception and postnatal physiotherapy exercises such as back care and pelvic floor exercises.

The service had a consultant specialist midwife in public health who was responsible for screening, smoking cessation and immunisation. During the last inspection, the trust did not offer an immunisation programme. On this inspection, we found this had improved as the service provided a Bacillus Calmette Guerin (BCG) vaccine clinic Monday to Friday on the day assessment unit. Birth notifications were sent to the clinic and the administrator or nurse reviewed the list and checked the blood test results. Referrals could also be received from the delivery suite or Mulberry ward.

We saw the database populated by the administrator during the inspection and saw the system tracked the dates where BCGs had been given to babies. The database was sent to the local NHS foundation trust. The BCG uptake was 55% with 1.5 whole time equivalent (WTE) staffing. However, since September 2019, the service had three WTE and was hoping to increase the uptake and reach NHS England's target of 100%.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood their responsibilities regarding consent. Women told us that medical staff informed them about the risks and benefits of obstetric procedures, such as caesarean section. Women we spoke with confirmed that staff asked them for their consent before proceeding with care and treatment. Written consent was obtained from women prior to surgery and we saw evidence of this in the maternity records we reviewed. Consent was either

taken in the delivery suite or the antenatal clinic and checked in theatres. Staff told us that consent for elective caesareans was taken in the preoperative clinic. All 34 records we reviewed showed consent had been taken where necessary. Women told us they were given enough information to enable them to make informed decisions about their care and treatment.

Staff demonstrated awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw posters on MCA and DoLS displayed, for example on Mulberry ward. Staff had access to specialist midwives, nurses and other professionals who had expertise in dealing with women in vulnerable circumstances, such as those with learning disabilities and mental health concerns.

Training for consent, MCA and DoLS was covered in the safeguarding adult's level two module. The trust provided the current compliance rates which showed that medical and midwifery staff in all the maternity areas met the trust target of 85% except for obstetric theatre staff and midwives on Mulberry ward with 82%. Midwifery students completed this module during specified times in their training and the current compliance rate was 71%.

Are maternity services caring?

Good 

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

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

However:

- Although most women told us they received enough information and had the opportunity to ask any

Maternity

questions, there were a couple of isolated incidents where women felt there was a lack of communication around the plan of care. We raised this with staff who addressed it immediately.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Women and relatives, we spoke with consistently told us about the kindness of staff across the maternity division. The following was representative of the feedback received: “Staff were very friendly and compassionate, “Staff do a wonderful job”, “Staff treated me with dignity and respect”, “Staff have been amazing and very thoughtful”, “The level of care and kindness shown to myself and my family was beyond my expectations” and “Staff were professional, organised and gave clear and concise information”.

Women told us they were treated with compassion, dignity and respect. Doors to women’s rooms were closed and privacy curtains were drawn when personal care or clinical examinations were carried out. Women told us doctors’ respected privacy with curtains and explained things well.

All the women we spoke with told us staff responded to call bells promptly. Women had noticed that both day and night staff were very busy but told us staff always had time to be patient and helpful.

Staff displayed thank you cards from women for the public to view throughout the maternity service. Comments in these cards included “thank you for looking after me so well”, “the professionalism is beyond description because I have been to a few hospitals, but you are number one” and “thank you so much for all your incredible work”.

We heard staff speaking to women politely and in a pleasant manner and observed good interaction by all grades of staff with women. Staff members introduced themselves and provided enough information. Women who had opted for elective caesareans told us the consultant explained the positives and the negatives and did not pressure the patient to change their mind.

Although most women told us they received enough information and had the opportunity to ask any

questions, there were a couple of isolated incidents where women felt there was a lack of communication around the plan of care. We raised this with staff who addressed it immediately.

We observed staff interacting with women who had arrived in triage and helped direct them to where they needed to go. We spoke with postnatal mothers who told us they were happy with their one to one care during labour. Several women we spoke with had returned to the maternity service having had a great experience with their first child.

The NHS Friends and Family Test (FFT) was launched in April 2013. The test asks people who use services whether they would recommend the services they have used, giving the opportunity to feed back on their experiences of care and treatment. The trust provided the FFT results for the last 12 months which showed the maternity service had been working on improving the response rate and capturing feedback from all the maternity areas including community. For example, the number of responses in September 2018 was 73 in comparison to 309 responses in September 2019. FFT results for September 2019 showed 94.5% of women overall would recommend the service to friends and family. The breakdown FFT results by each area was: antenatal clinic 83%, day assessment unit (Magnolia ward) 97%, delivery suite 94%, lilac birth centre 100%, community 100% and Mulberry ward 95%.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women’s personal, cultural and religious needs.

Staff provided compassionate care and emotional support to patients to minimise their distress. Staff involved women and their relatives in assessing and meeting their emotional and social needs, which was understood as being crucial in the expecting mother’s care. Women were offered free antenatal classes for emotional support and staff told us these could be booked online or face to face. Women we spoke with felt cared for, treated with respect and dignity and involved in their care.

There was ongoing assessment of women’s mental health and well-being during the antenatal to the postnatal

Maternity

period. The information booklet 'Your Pregnancy Care at Whipps Cross Hospital' included advice on perinatal mental health and the Ruby team. The maternity service had access to the Ruby team, the vulnerable team and psychiatric team who provided additional care, support and treatment for women with mental health concerns as needed. Once the expecting mother was 32 to 34 weeks, care plan meetings were arranged, and attendees included the consultant perinatal psychiatrist, specialist midwife, social worker, the expecting mother and their relatives.

The information booklet 'Going Home: our guide to postnatal care at home' included information on groups for postnatal depression advice, feeding, bathing, support with excessively crying, sleepless and demanding babies and sleeping.

There was access to national and local advisory groups such as Sands (stillbirth and neonatal death charity), to offer both practical advice and emotional support to women and their families. The service displayed bereavement leaflets by Sands which included deciding about funeral, information for grandparents and partners and supporting children when a baby died. Sands provided a memory card for grieving families to take pictures.

'Maternity mates' was a programme sponsored by the local borough and Barts charity. The programme buddied up local female volunteers with women who were disadvantaged (including those who were homeless) to provide emotional support before, during and after the baby was born. This included support during appointments, labour, providing information on pain relief, birth planning, breastfeeding and introductions to local children's centres and mother and baby groups. Where possible, the allocated volunteers spoke the same language as the expecting mother. The local borough trained the volunteers to provide practical and emotional support. Women would be referred to 'maternity mates' once the inclusion criteria were met.

We spoke with a woman who had a high risk pregnancy and had been admitted regularly over the last 6 weeks. We were told she "couldn't fault the care received" and she was involved in decisions with midwives and doctors.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Women we spoke with said they had been involved in the plans and decisions around their care. Women told us they were able to express their concerns and felt their anxieties were listened to and felt reassured.

Staff involved partners in the parent education classes and invited them to attend the tour of the facilities and the 34 week scan for the birth plan. The service offered 'becoming a dad' workshops which covered baby bathing, keeping baby safe, physiology of labour and breastfeeding, dealing with a crying baby, father scenarios and dad's day versus mum's day. Community midwives offered flexible times for education classes during the evenings and weekends, either on the hospital site or in the community in health centres or children's centres.

The service used patient feedback to make service improvements. For example, women had requested for the antenatal clinic not to be located next to the scanning room as the heartbeat of the child could be heard. This was insensitive for mothers who had miscarried, and the service had factored this feedback into the redevelopment plan for the antenatal clinic.

One woman and her partner gave positive feedback about the first admission and the re-admission four weeks after delivery. They felt staff listened to their concerns and provided clear information.

The parent education team had organised a free programme that offered pregnancy yoga and staff told us they had received positive feedback from women. The service also offered classes in reflexology, aromatherapy and active birth workshops.

NHS choices included feedback from women who had mentioned blood tests being lost in antenatal clinics. We discussed this with staff in the antenatal clinic who told us about an incident where a blood test had been lost. The incident was investigated and found that a tracking system was not in place with pathology. The trust completed a risk assessment and addressed the tracking issue.

Are maternity services responsive?

Maternity

Good 

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service exceeded the Better Births Strategy's national target for the percentage of women booked into continuity of care (CoC) pathways and personalised care.
- The maternity service was refurbishing the estates to improve women's experience and kept expecting mums informed ahead of their appointments.
- The service had introduced one-stop clinics; for example, the one-stop twin clinic, to improve patient experience by reducing the number of appointments and visits to the hospital.
- The trust had suitable arrangements in place for people who needed interpreting and advocacy services.
- The trust's chaplaincy team provided spiritual, pastoral and religious support to patients, visitors and staff across the trust and was available for everyone.
- The service had a bereavement midwife who completed follow ups via telephone for up to three months for grieving mothers, arranged a face to face session at three months and provided support during the consecutive pregnancy by arranging early scans.
- Women who were able to eat and drink could choose their meals from a selection of menus which included gluten free and halal choices. There was a local supermarket on the hospital site to purchase snacks and drinks.
- The trust had individualised 'hospital passports' for patients with learning difficulties which included details such as likes and dislikes, to help staff understand the patient and make them more comfortable.
- Although the service had limited information in different languages, we saw a welcome sign in the delivery suite in 36 different languages which included Gujarati, Tamil, Gaelic, Punjabi, Spanish and Welsh.

- The service dealt with concerns and complaints appropriately and investigated them in the required time frame and learned lessons from the results, which were shared with all staff.

However:

- Most women and relatives we spoke with told us the car parking at the hospital presented challenges in reaching appointments on time.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The first pregnancy appointment (also known as booking appointment) took place either at one of the Bart's Health hospitals, in the local GP surgery or children's centre. The midwife would obtain information on the patient's medical history, previous pregnancies and health and wellbeing. The midwife provided information on how to access antenatal classes and what choices were available during pregnancy including screening tests and delivery options. Expecting mothers were welcome to have their husband, partner, mother, or friend attend with them.

Uncomplicated 'low risk' pregnancies were booked with a team of community midwives (known as midwifery led care). The community midwives provided antenatal care in community clinics in health centres, children centres or GP surgeries. The patient would only see an obstetrician if there were any problems or concerns with the pregnancy. For 'high risk' pregnancies with increased body mass index (BMI), diabetes or multiple pregnancies, the specific risk factors determined if women had a named obstetrician at the hospital or a GP/midwife in the community. Scans always took place at the hospital.

Antenatal care included invitations to attend regular appointments throughout the pregnancy to monitor the health and wellbeing of the expectant mother and her baby. The appointments also provided a platform for women to discuss any concerns or worries that they may have.

The fetal medicine team offered women and their families support through pregnancy and antenatal

Maternity

screening when a congenital or genetic condition might be suspected or diagnosed. The fetal medicine team also provided specialist scanning for women with complex pregnancies such as with twins or triplets. Clinical leads for the clinic told us sonographers would scan anomalies and the clinic was meeting the 72 hour target. All invasive procedures were referred to the tertiary clinic in Royal London Hospital. We saw evidence that the pathways complied with The NHS Fetal Anomaly Screening Programme (FASP) guidance.

Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led care was offered to women with an uncomplicated pregnancy which included a home birth or delivery in the birth centre. This was in line with national guidance (NICE Antenatal care for uncomplicated pregnancies: CG62). Between October 2018 and September 2019, from the 71 women who chose to have a home birth, 53 women had a home birth and 18 women were transferred to the delivery suite before or during delivery. Women with previous medical condition, complication of pregnancy or had experienced previous complications in pregnancy or labour, were advised to have their baby on the delivery suite, which was obstetric-led.

The service offered a vaginal birth after caesarean section (VBAC) clinics and birth options clinic to support women to explore their birth choices for their current pregnancy in line with national guidance.

In October 2017, transforming services together (TST) had been superseded by the maternity transformation programme (known as Better Births). The Better Birth Strategy aims included: increasing continuity of carer (CoC) for women, personalised care, improving women's experience and safety. The implementation of the case loading team had increased the CoC rates from 1% in October 2017 to 24% in March 2019 (against national target of 20%). The service locally aimed for greater than 40% by end of quarter four. The service was also launching a new community team configuration to support CoC in January 2020.

Whipps Cross Hospital achieved 64% for personalised care in April 2019 (against national target of 50% by March 2020) and aimed to reach 75% by March 2020. The maternity dashboard showed that between April 2019 and September 2019, 97% of women had one to one care

in established labour (against the trust target of 95%). The service was refurbishing the estates to improve women's experience and had created a monthly service user experience board for women's health what monitored women's experiences and steered strategy. Additional funding had been secured to expand the immunisation clinic to provide flu and whooping cough clinics by December 2019. Staff had received the training and a dedicated fridge had also been arranged.

During the last inspection, only 11% of women had a named midwife. On this inspection, we found some improvements had been made as this figure had increased to over 30%. In May 2019, the service had restarted the 'pregnancy circles' outreach programme which provided women with a named midwife from 16 weeks. Currently, the research team had recruited 19 women, all of whom have a named midwife.

Mulberry ward, Magnolia ward and the delivery suite had waiting areas which had sufficient seating, toilets and water fountains. The entrance to the maternity unit had vending machines with snacks and drinks and hot drinks. All the maternity areas had pay phones, male and female toilets and disabled facilities were also available. There were facilities within the hospital site to purchase hot food, snacks and drinks. Women told us that although the tea shop in the antenatal clinic was not always open, this wasn't an issue as there was a local supermarket on site.

Car parking costs were discounted for women in labour or those being induced. Women would pay the minimum for a two hour stay and then be excluded from charges. However, most women and relatives we spoke with told us the car parking at the hospital presented challenges in reaching appointments on time. One woman told us she was 39 weeks pregnant and found parking 15 minutes' walk away.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Each maternity area displayed the visiting times at the entrance. Each waiting area had adequate seating and access to water fountains. The maternity lounge on Mulberry ward had a television, handwashing facilities

Maternity

and displayed a range of Royal College of Obstetricians and Gynaecologists (RCOG) leaflets which included gestational diabetes and premature labour. Mulberry ward had a milk kitchen which had restricted access. There was a dedicated fridge to store milk for 24 hours. All milk bottles were labelled with the mother's name, date and time and each bed number had a numbered tray.

The delivery suite allowed partners to stay 24 hours and the 24 hour triage allowed one visitor to accompany the expecting mother. Lilac birth centre allowed partners to stay 24 hours but limited visitors to no more than two (including partners) within the visiting times. The hospital had an 18 bedded neonatal unit where unwell babies could be transferred to and parents would be able to visit their baby at any time.

Although Mulberry ward did not allow partners to stay overnight, partners were allowed between 08.00 to 10.00pm. The ward had previously allowed partners to stay overnight but stopped this in November 2018 due to issues such as partners arguing and disrupting other women. However, the ward manager told us an individual approach was applied and where there was a need for a partner to stay overnight, the woman would be allocated a side room where possible. The number of visitors was limited to no more than two (including partners) within the visiting times and women's own children could visit but for other children, they had to be 16 and over.

Although the service had limited information in different languages, we saw a welcome sign in the delivery suite in 36 different languages which included Gujarati, Tamil, Gaelic, Punjabi, Spanish and Welsh. The 'screening for you and your baby' leaflet was available in 12 different languages such as Romanian and Punjabi.

The trust had individualised 'hospital passports' for patients with learning difficulties. The passport was a communication book which included details such as the likes and dislikes, their interests and favourite items. This information helped staff understand the patient and make them more comfortable.

The service had two bereavement suites (Rosebud rooms) in a quiet area of the delivery suite. This meant that bereaved families did not meet labouring women or those that had babies with them. Each room had an ensuite shower and toilet, a kitchenette, double bed, chairs that converted into sofa beds, music and fitted

wardrobes. Access to the suites was restricted and staff told us families were given a flower badge to represent families who had lost a baby so that security staff did not stop them.

A specialist bereavement midwife provided training for staff and supported parents and families following still-born, miscarriage and neonatal death on the wards and clinic. The bereavement midwife completed follow ups via telephone for up to three months for grieving mothers and arranged a face to face session at three months.

The Rosebud clinic was led by two consultants and reviewed all women with stillbirth, neonatal deaths and miscarriage. The grieving parent was seen by a midwife with the post mortem report to discuss the next pregnancy. The bereavement midwife supported bereaved women during the consecutive pregnancy by arranging early scans.

A cold cot was available which meant that babies could stay longer with parents. The cot had a lid which allowed transfer to take place in a discreet way supporting grieving families. Memory boxes were made up for parents who suffered pregnancy loss and could be tailored for multiple pregnancy loss. The service provided magic ink and clay to allow families to take hand and foot prints.

The service provided women with the choice to have the hospital arrange pregnancy loss tissue to be sensitively disposed or supported families to make private arrangements.

The trust had a chaplaincy service, which provided spiritual care and religious support for patients, partners and relatives as needed. The Chapel and the Muslim Prayer Room were situated on the first floor in the main hospital building.

Two local mental health NHS foundation trusts provided mental health support to the hospital. Both providers had perinatal teams who liaised with the midwifery service. One of the providers had a Perinatal Parent Infant Mental Health Service (PPIMHS) and MDT meetings were chaired by the perinatal psychiatrist on the maternity unit. Women who did not meet the criteria for PPIMHS were

Maternity

referred or signposted to the Improving Access to Psychological Therapies (IAPT). The hospital also had a 24 hour psychiatric liaison service on site when PPIMHS was not available.

The antenatal service offered free yoga classes to all women to improve physical and psychological health in preparation for birth.

The service introduced an Anti-D clinic which offered a free fetal DNA test in May 2019. If the baby tested negative and with agreement from the mother, the baby would not receive Anti-D. This reduced unnecessary appointments and was less invasive.

The service had introduced one-stop clinics to improve patient experience by reducing the volume of appointments and visits to the hospital. For example, the one-stop twin clinic was set up in March 2019 and provided a scanning appointment, midwifery support and an appointment with the consultant. The service had plans to launch the one stop clinic for gestational diabetic (GDM) women in January 2020.

The maternity service offered birth reflections clinics as a postnatal service for parents who wished to discuss their birth experience and express their feelings. The exclusion criteria included bereavement and mental health and the clinic took place alternate weeks.

The service provided women and their families relevant information on the trust website and in patient information leaflets (PILS). Example of PILS included baby movements, BCG vaccinations and perineal tears.

Interpreting services could be booked where a woman's first language was not English, and midwives had access to a telephone-based and face to face translation service. Some staff told us they struggled to access the face to face as it was based in Newham. The service offered text relay for women with hearing difficulties and staff told us access to British Sign Language had improved.

The service met the cultural and religious needs for meal preferences. For example, patients could order Halal, West Indian and Gluten Free. Parents told us they were happy with the lunch menu and choices.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Expecting mothers could be referred to Barts Health maternity services in three ways: via the GP, the community midwife or self-refer either in person or using the online referral form for a specific hospital within the trust. Once the referral had been received, the expecting mother would receive a booking appointment with a midwife usually before week 10 of the pregnancy. At this appointment, the individual care plan for the patient would be discussed and plans made for future appointments.

Between April and September 2019, the percentage of women booked by 10 weeks was 56.6% (which had improved from the 50.2% between April 2018 and March 2019). The percentage of women accessing services and booked before 12 weeks was 98.1% (against trust target 90%).

The maternity dashboard from April 2019 to September 2019 showed there were 2167 births. From these, 83% of deliveries were in obstetric unit, 14.2% in co-located midwife led unit and 1.7% were homebirths.

The hospital's maternity day assessment unit (Magnolia ward) provided care for women who required additional monitoring during pregnancy. Magnolia ward accepted women who were more than 20 weeks pregnant and had symptoms such as abdominal pain, severe itching, reduced movements, high-blood pressure and waters broken (without contractions). Women could be referred by their midwife, GP or obstetrician or self-refer by phoning the unit. The midwife on the unit would assess the patient first and the obstetric team may also review the patient if needed.

The 24-hour walk in triage was located within the delivery suite which meant obstetric teams were able to review women with complications when needed. Although women could be referred by community midwives, staff told us most of the women self-referred. Women with greater than 18 weeks gestation were seen in triage for acute needs. Reasons for attendance included: active labour, waters broken, bleeding, abdominal pain, anxiety. Staff told us that as there was only one midwife in triage,

Maternity

it could be challenging at times to answer the telephone. Staff had raised this with senior leads and as part of the refurbishments, the day assessment unit will be co-located next to the triage in the delivery suite. This meant there would be improved administration cover to answer the telephone.

The service offered elective caesarean sections on Monday (half day), Wednesday (full day) and Thursday (half day) and the team included one ODP, two scrub nurses, one HCA and one consultant anaesthetist. Preoperative clinics took place in outpatients. The service had an enhanced recovery obstetric surgery pathway which included early eating and drinking, encouraging oral intake of fluids, mobilising as soon as possible, removing the catheter six to eight hours after surgery, regular analgesia and breast feeding support.

Postnatal follow ups took place within 72 hours. The community midwife would visit the mother within 24 hours and where this was not possible, triage would take place via telephone call. If the mother was well, they would attend the clinic on day five. For women who did not want to attend the clinic, community midwives would continue the home visits until the health visitor made contact. Although women were usually discharged after two weeks, community midwives could keep women on the list for up to 28 days.

The service did not collect waiting times for antenatal clinic. The antenatal clinic displayed waiting times for clinics for women to see and staff told us that if there was a wait over 30 minutes, this would be logged as an incident. Women in the antenatal clinic told us the appointments were never cancelled and they didn't have to wait long to be seen.

Although the service documented the time the woman arrived in triage (IN) and the time the woman is initially seen (TRIAGE) in the paper records, the data had not been collated into a report. Women were assessed using a traffic light system (RAG rating) which gave guidance on how soon the full assessment should take place. The service provided an anonymised sample of attendance timings for 8 and 9 October 2019 which showed the majority of women as seen immediately or within 5 minutes.

The antenatal clinic followed the trust policy in managing 'do not attend' (DNAs). Women who missed their first

appointment were offered a second appointment. If the second appointment was missed, the midwife called the expecting mother and if there was no response, informed the community midwifery teams who would carry out a home visit. Each DNA and action taken was recorded on the electronic system. Community midwives had a similar process to manage DNAs. For women who missed their first appointment, the midwives would attempt contact to rearrange. If the expecting mother missed the second appointment, the midwife would deliver a letter by hand and inform the safeguarding team.

In February 2019, the maternity service introduced a new dashboard to monitor the performance in two key areas; utilisation of all resources used and the 'did not attend' (DNA) within the antenatal service. Performance was discussed in the fortnightly maternity and neonatal service operational meeting. Trust data between February and September 2019 showed the DNA rates for nuchal scans, anomaly scans, fetal medicine unit (FMU) scans, one-stop twin clinic and obstetric phlebotomy service was either within or close to the trust target of less than 10%. The DNA rate for first bookings had been less than 10% between February and August 2019 but had increased to 11.1% in September 2019.

The following antenatal services did not meet the DNA target for September 2019: first booking clinics on weekday (12.2%), midwifery follow ups (20.6%), intermediate risk consultant follow ups (20.1%) and high-risk consultant follow ups (13.8%). The service had an action plan to address DNAs which included: administration staff to call all patients 48 hours before their appointments as a reminder and if appropriate reschedule at the time of the call. The service had also reviewed clinic letters to ensure patients understood the timing of appointments and how to rearrange if needed and the letters now included maps and directions around the hospital site.

The service audited obstetric readmissions between April and July 2019 having identified an increased number of women being readmitted within 42 days of discharge. However, audit data showed that readmission rates had decreased from 55 readmissions between April and July 2018 to 44 between April and July 2019.

Maternity

Between October 2018 and September 2019, there were 4186 births at the hospital. Of these, 20 women (0.5%) were readmitted with puerperal sepsis and 33 women (0.8%) were readmitted due to infection.

The maternity service offered a weekly audiology clinic on Mulberry ward. Although security arrangements were in place, staff told us the number of visitors during clinic times presented challenges in managing security. We observed the reception area of the ward during the clinic time and saw at least five visitors arrive in 15 minutes for the audiology clinic. Each time, a staff member directed the visitors to use the alcohol gel and report to the reception desk. Staff told us the clinic would be scheduled for the whole day. We raised this with senior leads who acknowledged the increased number of visitors during clinics times and were trying to find a suitable space to relocate the clinic.

The female genital mutilation (FGM) clinics had seen 249 women in the 12 months of which 98% of women self-referred. The clinic had completed 21 deinfibulations and 100% of women received counselling on illegality of FGM, referrals to social service, safeguarding referrals and system entry on the NHS spine portal.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

The service displayed contact details for the Women Advice Liaisons Service (PALS) throughout the service. All patient information leaflets had contact details for the PALS team and the women we spoke with had awareness on how to make a complaint.

The service discussed complaints in the monthly quality and safety meeting to ensure appropriate actions were taken. Staff told us that complaints were also discussed at the safety huddle, handovers and the governance newsletters to share any learning.

Between 14 October 2018 and 15 October 2019 there were 43 reportable complaints logged regarding the maternity services at Whipps Cross Hospital. The average time to respond for the maternity service in the reporting

period was 34 days against the site average of 29 days. As the service resolved most of the issues raised locally, reportable complaints were more complex and took more time to investigate and respond to.

The main key performance indicator (KPI) for the trust was the percentage of complaints responded to within the timescale negotiated with the complainant. The service achieved 90% compliance against this KPI with 41 complaints closed in the reporting period. Of these, 39 complaints were responded to within the deadline and the remaining two complaints are under investigation. The service did not refer any complaints to the Parliamentary and Health Service Ombudsman (PHSO) within this reporting period.

The maternity areas which received the most complaints were antenatal clinic (37%), delivery suite (33%), Lilac birth centre (15%) and Mulberry ward (15%). The most common themes identified were diagnosis and treatment including delays in care/treatment (44%), communication including written, verbal and electronic (46%) and appointments/clinics (10%).

Are maternity services well-led?

Good 

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

- Although the divisional team structure had been finalised six weeks prior to the inspection, staff demonstrated awareness of the leadership team and described them as supportive, visible and approachable.
- The service had highly dedicated staff who were very positive, knowledgeable and passionate about their work.
- Senior leads understood and managed the priorities and issues the service faced. Staff felt listened to if they raised concerns.
- Midwifery and medical staff of all grades spoke of good teamwork and development opportunities.
- The service had highly dedicated staff who were very positive, knowledgeable and passionate about their work. Staff described the maternity service as a “family”.

Maternity

- The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- There were systems in place to identify and monitor risk, issues and performance. Senior leaders and managers of the maternity service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions.
- Despite trust wide issues impacting the service such as pharmacy resources and updated trust guidelines being published on the intranet, senior leads put mitigation steps in place to minimise the impact on patient safety.
- During the last inspection, the poor access to information technology (IT) systems meant the community midwives could not do the booking visit. On this inspection, we found improvements had been made as each community midwife team had a laptop and the WIFI access in the community was being finalised to be in place late November/early December 2019.
- Although some agency staff did not have logins for the electronic system, they could access the electronic records easily through other staff. We raised this with the senior team as the lack of access could also affect incident reporting and accessing trust guidelines. The service had previously issued temporary cards which had all gone missing. After the inspection, the trust had implemented generic logins for all agency midwives who had previously not been able to access the electronic system.
- The service actively and openly engaged with women, staff, the public and local organisations to plan and manage services.
- Senior leads encouraged staff to be involved in quality improvement programmes which included process mapping and patient experience.
- Although staff demonstrated awareness of the trust's values, we did not see the values displayed throughout the maternity service. We raised this with senior leads and found this had been address on day two of this inspection.

However:

- Although senior leads told us the intranet had information on freedom to speak up guardians, we found staff had inconsistent awareness of them.

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 women and staff. They supported staff to develop their skills and take on more senior roles.

The maternity service was part of the trust's Women's and Children division which included gynaecology, genito-urinary medicine, neonatal and paediatric services. The maternity service was led by a triumvirate team that included the head of midwifery and gynaecology, divisional director and the divisional manager. The head of midwifery was supported by lead midwives (matrons) in each department, consultant midwives for specific areas and ward managers for each department.

Although the divisional team structure had been finalised six weeks prior to the inspection, staff demonstrated awareness of the leadership team and described them as visible. Senior leads told us the reason for the change was to improve overall accountability which lied with the divisional director. We interviewed the senior management team who demonstrated an awareness of the performance within the maternity service along with its challenges.

Staff we spoke with told us that managers were supportive and approachable, and felt their concerns were listened to. Ward meetings took place monthly and were advertised in advance and was a forum for staff to raise any concerns. We reviewed the October 2019 minutes for Lilac birth centre and the delivery suite (band 6) meeting. We found the minutes documented the list of attendees and included discussion on staffing, governance, incidents and appraisals.

Both midwifery and medical staff of all grades spoke of good teamwork and development opportunities. For example, the trust had provided funding for four staff from each trust site to complete the advance clinical practitioner (ACP) training for midwives in January 2020.

Vision and strategy

Maternity

Senior leaders told us they were proud of the service and that they were delivering good care.

The maternity service had six objectives for 2019/2020 which were categorised by: safe and compassionate care, efficient and effective services, service transformation, developing our people, improving our infrastructure and leading the way in research and education.

The women's and neonatal service transformation had secured funding of £6.7 million by Barts Charity in November 2017 and the works for the project commenced in January 2019. Areas of development included day assessment centre, antenatal clinic, lilac birthing unit, neonatal unit and delivery suite. Plans included an emergency corridor to link the maternity unit with the main hospital eliminating the need to use an ambulance to transfer women who fall seriously ill to the intensive care or high-dependency units. There would also be a new research hub which would work in partnership with the Royal London Hospital and Newham University Hospital. The research would provide the evidence to improve outcomes for women and their babies.

Senior leads told us the vision for the maternity service was to focus on continuity of care with better births strategy by promoting and personalising care. For example, the maternity service wanted to reduce the attrition rate of expecting mothers from 19% to 14% by 2021 and increase the number of births outside of an obstetric unit to 30% by providing a 'state of the art' midwifery-led birthing centre.

Although most staff demonstrated awareness of the trust values ('We Care'), we did not see the values displayed throughout the maternity service for both the public and staff to see. We raised this with senior leads on day two of the inspection and found that it had been addressed on day three. We saw the values displayed near the entrance of Mulberry ward and on the live notice board in the delivery suite.

Senior leads told us the 'We Care' values were integrated into the appraisal process and team meetings. 'We Care' stood for welcoming, engaging, collaborative, accountable, respectable and equitable. Staff were required to include examples of how they demonstrated the values in their appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt supported by their managers and colleagues. They said it was a friendly team and they felt listened to if they raised concerns. Most staff commented that the team was like a family and they prided themselves on good teamwork. Junior doctors said they felt well supported by consultants and described the culture as positive. Staff described the environment as supportive to newly qualified staff with good team work ethic.

Senior leads were proud of their staff and told us several staff members had been working in the trust for years. Senior leads told us there was an atmosphere of togetherness especially during difficult times. Despite the staffing challenges in delivery suite, senior leads described the culture as stable.

The service had completed a whistleblowing investigation in the community midwifery team leaders and received support from the trust culture change team. This resulted in 50% change in leadership with complete reconfiguration of community services including the renaming of teams, change in geographical areas and rotating midwives in different teams. Community midwives told us they had noticed the improved culture after the changes had been made.

The trust had a 'star of the month' scheme and the maternity service displayed 'star of the month' certificates with staff photos. Staff were awarded with a voucher and a star of the month certificate. Barts Health Heroes Award recognised staff at a special awards ceremony for going above and beyond care for patients and colleagues. Teams from each trust site attended the awards. Each individual winner received £500 and teams received £1000, sponsored by Barts Charity. In addition, every nominee received a certificate honouring their achievement and an invitation to a celebratory lunch. Staff told us the teams had regular social nights out and the social committee advertised social trips.

Maternity

Most staff we spoke with told us they had not witnessed any bullying or harassment in the department. The trust had equality and diversity forums such as the Black and Minority Ethnic (BME) network which met quarterly.

There were processes in place to support staff during challenging circumstances. Staff told us they had access to debriefing sessions to facilitate reflective practice and talking about their feelings. Although senior leads told us the intranet had information on freedom to speak up guardians, we found staff had inconsistent awareness of them.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure for the service and staff at all levels were clear about their roles and understood their responsibilities. Staff were aware of how to complete incident reports and were encouraged to do so. Most staff we spoke to had completed incidents and received feedback from managers.

The Women's service had monthly quality and safety meetings which fed into the monthly Women and Children's divisional board meetings. We reviewed the quality and safety meeting minutes for July, August and September 2019 and found there was consistency in the format and structure of these meetings. The meeting agenda included discussion on outstanding risks, serious incidents, staff rota, updates from each area, staffing, complaints, education and patient feedback.

The triumvirate team also attended the monthly Hospital Executive Board (HEB) meetings where the division's performance review was discussed. We reviewed the minutes for the September 2019 which included discussion on key performance indicators (KPIs), morbidity, governance, complaints, health inequalities and workforce.

The monthly perinatal health board meetings ensured triangulation was in place for learning from serious incidents across all the hospital sites in Barth Health NHS Trust. We reviewed the minutes for June, July and September 2019 and found there was consistency in the format and structure of these meetings. The set meeting

agenda included actions from last meeting, neonatal update, midwifery board update, standards and variation, cross site audit days and governance. The minutes showed the cross site director of midwifery attended alongside representation from the other hospital sites and the venue for the meetings was rotated across the trust sites. Staff told us the learning from cross sites incidents was shared through daily safety huddles and newsletters. We attended the safety huddle and saw there was discussion around a serious incident that occurred at Newham University Hospital.

The maternity service used a clinical performance dashboard to monitor activity, outcomes, performance and helped identify patient safety and quality issues. This was in line with national recommendations (RCOG Maternity Dashboard: Clinical Performance and Governance Score Card, Good Practice No.7, 2008). The dashboard tracked monthly performance against locally agreed performance measures. A traffic light system was used to flag performance against agreed thresholds. The maternity dashboard was regularly discussed at departmental, divisional board meetings and trust board.

The monthly women's governance dashboard (which included obstetrics and gynaecology) included the number of risks, serious incidents, mortality, incidents, falls, incidents of MRSA, duty of candour, complaints and compliments. The service displayed 'spotlight on women's governance' newsletter each month. We saw the September 2019 newsletter displayed in the staff areas and found it included information on risk meeting messages, number of incidents/never events and complaints with theme analysis, risks included in the risk register and positive feedback for the team. The governance board in the delivery suite displayed the quality and safety meeting minutes, message of the week, risk register, duty of candour reminder and the performance dashboard.

In August 2019, the maternity service had an unannounced 'mock inspection' by another NHS Trust. We reviewed the findings of the report dated October 2019 and found most of the findings were similar to our findings. Although the report was received just before our inspection, the service had put in place an action plan to address the areas of improvement identified.

Maternity

Staff told us that the senior leads and senior midwives walked around each maternity area on clinical Fridays, checking for cleanliness, equipment checks and emergency medicines trolleys.

Each maternity area had monthly team meetings except for the day assessment unit (Magnolia ward) that had team meetings every two to three months as the team was small.

The maternity service kept staff up to date through several newsletters such as the maternity newsletter, risky business newsletter, message of the week and the monthly governance newsletter. For example, the maternity dashboard poster for September 2019 was titled 'Births in Spotlight' and included a range of information such as the number of births separated by place and type of delivery, midwife: birth ratio, breastfeeding rate at discharge, bookings completed by 10 weeks and earliest/longest gestational age.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Senior leaders and managers of the maternity service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. We saw that risks identified on inspection were on the risk register, including updating trust guidelines on the intranet, staffing, use of agency and replacement of the ultrasound machines in the antenatal clinic (ANC). The register also included availability of baby tags and IT in community.

Senior leads told us there was a separate risk register for the refurbishment work which included issues such as infection prevention and control and delivering business as usual throughout the remodelling of the building. We reviewed the risk register and found risks were appropriately documented with named risk manager, board risk owner, status, had actions identified to reduce risks with progress notes, dates when the actions were last reviewed and risk scores.

The division managed risk by identifying risk through discussion at monthly quality and safety meetings where

all staff could attend and raise concerns or staff could raise risks with their ward manager who attended the meeting. The risk was discussed and if agreed, a risk assessment was completed and presented at the divisional quality and safety meeting. If agreed, the risk was added to the risk register and the electronic incident system.

Senior leads told us that although staffing levels had improved since the last inspection, factors such as Brexit, staff on long term sick and maternity leave hadn't helped. Additional hurdles in recruitment included lack of London weighting, poor calibre of candidates applying as they failed the 'skills and drills' test and poor turn outs to recruitment events. The service mitigated the staffing levels risk by using bank and agency staff and maintaining the recruitment drive. Senior leads told us they had interviews arranged in late October 2019.

The trust had arranged for an external review of their recruitment criteria to ensure they were not being too difficult in the assessment process with another local hospital and no concerns had been identified. Staff feedback in the 100 voices survey highlighted that staff felt vacancies were not being recruited for. The senior leads addressed this by ensuring there was improved communications with staff highlighting what was being done as part of the recruitment drive and the challenges faced.

We attended the weekly divisional risk multidisciplinary team (MDT) meeting which was well attended by a range of midwifery staff (matron, ward managers) from all maternity areas including community, medical staff (consultant and registrars from obstetrics, gynaecology and paediatrics) and the lead sonographer. The meeting reviewed the previous serious incidents and complaints. We saw evidence that outstanding actions were reviewed, and progress was made against most actions.

The intranet had information on major incidents and the trust tested the major incident plan annually with live exercises every three years involving partner organisations and stakeholders.

Information management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Maternity

The maternity service used a mix of paper-based and electronic records. Computer stations were available so that staff could access the intranet and internet. Staff were aware of how to use and store confidential information. We found paper records were stored securely and staff locked computers preventing unauthorised access.

However, some agency staff did not have logins for the electronic system and used the yellow book for their documentation. Although agency staff told us they could access the electronic records easily through other staff, we raised this with the senior team as the lack of access could also affect incident reporting and accessing trust guidelines. Senior leads told us they had previously issued temporary cards which had all gone missing and were exploring the governance around other options. After the inspection, the trust had implemented generic logins for all agency midwives who had previously not been able to access the electronic system.

During the last inspection, the poor access to information technology (IT) systems meant the community midwives could not do the booking visit. On this inspection, we found improvements had been made as each community midwife team had a laptop. The trust was finalising the WIFI access in the community by working with a local NHS Foundation Trust. Senior leads told us this would be in place by late November/early December 2019 and would make a big difference.

The service submitted data to external bodies as required such as MBRRACE-UK, which enabled the service to benchmark performance against national outcomes.

Noticeboards in maternity areas displayed a vast range of information for women and their families. Information boards were displayed in each area and included the planned versus actual staffing for each shift that day. The entrance area displayed the map of the hospital, leadership chart, visiting times for each area, friends and family test (FFT) results, photographs of the leadership team and executive team and the previous CQC ratings.

Staff notice boards included information on what's on the risk register, message of the week and duty of candour. The live information board in the delivery suite kept staff up to date with team information. Staff received communication through huddles, handovers and newsletters.

The service had several social network groups which helped share communication; for example, sharing additional shifts. The same network groups had been used by the trust to send urgent messages around the completion of Modified Early Obstetric Warning Score (MEOWS).

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.

Staff gave the friends and family test (FFT) forms to women at the point of discharge so that they could give feedback in relation to the care they had received. The service captured FFT data for all the maternity areas including the community. The service worked closely with the patient experience lead to improve their FFT. Staff told us the service would be getting tablets to make data inputting easier before the end of the year. Feedback was also collected through social media forums such as NHS Choices, Facebook and Twitter. Women who used maternity services were encouraged to give feedback on the quality of service they received.

In May 2019, the maternity service completed '100 voices' to collect women's views of antenatal and postnatal services. Although women overall were satisfied, the service used the feedback to make improvements. For example, 26% of women were not offered a choice of venue for antenatal care. Next steps included ensuring women were given written information on choice of venues available and recording discussion on choice in notes.

The maternity refurbishment project had involved clinical and multidisciplinary teams throughout the design phase and a group of women who had delivered their babies at hospital were also involved in refurbishments design. Staff told us they were excited about the redevelopment work and received regular updates. Staff kept expecting mums informed ahead of their appointments and the service provided teddy bears to women as a gesture to 'Bear with us'. The service also produced monthly

Maternity

maternity bulletins detailing what works were near completion and the works planned for the coming months. We evidence of this in the bulletins between January 2019 and September 2019.

The service had developed strong links with the local Maternity Voices Partnership (MVP), which was an independent multidisciplinary committee made up of user representatives, maternity professionals and other stakeholders such as clinical commissioning groups (CCGs).

The staff survey 2019 results indicated 66% of staff said they did not have opportunity to make improvements happen in their own area of work. The trust responded in several ways. Examples included identifying a champion midwife on Mulberry ward to lead on the induction of labour quality improvement (QI) project and providing staff with protected time to be involved in QI projects identified in their appraisal.

Results also showed that 67% of staff said they did not have the opportunity to show initiative in their role. As a result, midwives were given protected time to work with the assistant service manager on the 'outstanding place to work' QI project. In July 2019, the QI team gave out 'joy at work' slips to ask staff if they had a good shift, what went well, what went wrong, what mattered to them the most and would the staff member recommend the hospital as a place to work. By September 2019, improvements had been made to address some of the themes identified. For example, new water coolers were put in all staff areas, new equipment was made available and the service used 'Busy Bees' posters to improve communication.

Senior leads told us it was important that staff members felt valued and respected. The trust recently launched 'your voice counts' fortnightly workshops in September 2019. The workshops provided staff with the opportunity to meet with divisional leads to raise concerns and make suggestions.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The maternity service was involved in quality improvement programmes which included process mapping and patient experience. For example, the induction of labour (IoL) quality improvement project had revised the outpatient pathway, processed mapped every step of woman's journey through the IoL pathway and included patient experience feedback.

The national target for Better Births Strategy was to have greater than 20% women booked into continuity of care (CoC) pathways. During the inspection, the divisional team told us the hospitals current performance was 35% and the service was aiming for greater than 40% by the end of quarter four.

The maternity service was taking part in eight research studies and displayed information leaflets regarding the studies for the public to view.

Outstanding practice and areas for improvement

Outstanding practice

- The Female Genital Mutilation (FGM) team achieved the first UK court conviction against FGM in February 2019 and was a finalist for a national award for the Lotus clinic. The future for the FGM service was to target community education for schools, professionals and faith groups across Barts Health.
- The Ruby team had won a Royal College of Midwives (RCM) award in 2018 for their work in supporting vulnerable pregnant women.
- The maternity service was involved in quality improvement programmes which included process mapping and patient experience. For example, the induction of labour (IoL) quality improvement project had revised the outpatient pathway, processed mapped every step of woman's journey through the IoL pathway and included patient experience feedback.
- The service exceeded the Better Births Strategy's national target for the percentage of women booked into continuity of care (CoC) pathways and personalised care.

Areas for improvement

Action the provider SHOULD take to improve

Actions the provider SHOULD take to improve:

- The trust should continue addressing the high vacancy rates for midwifery staff, focussing on recruitment and staff retention.
- The trust should continue taking steps to ensure there is consistent hand hygiene practice and adherence to infection control related aspects of the uniform policy amongst staff.
- The trust should continue taking steps to ensure the National safety standards for invasive procedures (NatSSIPs) proforma checklist is fully embedded throughout the maternity service.
- The trust should continue taking steps to ensure staff consistently complete MEOWS and NEWS observations and where appropriate, the records should include any narrative to explain non-compliance.
- The trust should ensure the maternity service has sufficient pharmacy support to provide assurance that medicines reconciliations is taking place in line with trust policy.
- The trust should explore options to overcome the challenges staff faced with closing the 'to take away' (TTA) medicines loop when no contact was made with women to collect their medicines after being discharged.
- The trust should ensure that updated guidelines are published on the intranet for staff to use.
- The trust should take steps to ensure the parking facilities are suitable for women and relatives who access the maternity service.
- The trust should improve their data submission processes for the NHS safety thermometer to ensure the service can display the data on notice boards for staff or patients to view.
- The trust should collect waiting times for the antenatal clinic to evidence that there is timely access to the service.