Barts Health NHS Trust

Newham University Hospital

Inspection report

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Date of inspection visit: 15 June 2021
Date of publication: 17/09/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	
Are services responsive to people's needs?	
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Newham University Hospital

Requires Improvement 

Background to Newham University Hospital

Newham University Hospital provides maternity services to women in the London Boroughs of Newham and Barking. Between June 2020 and June 2021 Newham Hospital had 5,903 births. The booking and antenatal clinics take place at one end of the hospital where there are five ultrasound rooms.

A consultant led delivery suite on the first floor has 15 delivery rooms and a midwifery-led birthing unit has 10 rooms. A four-bedded recovery/observation unit caters for women who require close monitoring. This area is staffed by nurses and midwives with specialised training.

Staff have access to two obstetric theatres 24 hours a day. Larch ward, on the ground floor, has two sections, an 11-bed antenatal ward and a postnatal ward with 34 beds. There are two bays for transitional care. There is a further bay that staff can open if the ward is very busy. Six single rooms can be used by women with a medical need, or as amenity rooms for which a fee is paid.

A maternity day assessment unit, to which women can walk in during opening hours is open between 8am and 8pm to assess women over 18 weeks of pregnancy, and triage is open 24 hours a day. An early pregnancy unit is open 9am to 5pm on weekdays and 9-2pm at weekends for women with complications of early pregnancy. A maternity helpline is available from 10am to 8pm.

The service is supported by a local neonatal unit that cares for babies born from 27 weeks' gestation who need breathing or feeding support or short term intensive care, sometimes before being transferred to neonatal intensive care unit which provides the highest level of care to babies.

How we carried out this inspection

We carried out this unannounced focused inspection in response to concerns we received about the safety and quality of the maternity services. The concerns related to the governance and culture of the service. As this was a focused inspection our inspection activity focused only on parts of the safe, effective and well led key questions. This means we did not look at all key lines of enquiry in each of the domains.

We inspected maternity care throughout the maternity unit so we could get to the heart of the patient experience. During the inspection to understand the patient journey and make sure that women and babies were kept safe we visited triage, the antenatal ward, the postnatal ward, Larch ward, the delivery suite, the midwifery led birth centre, maternity assessment unit and the maternity booking centre.

We did not inspect the community midwifery team because the services were carrying out care within the community and we did not visit community services on this inspection.

We did not rate this service at this inspection.

Our findings

The team that inspected the service comprised of a CQC inspector, an obstetrician specialist advisor and a midwifery specialist advisor.

The team spent a day on site at the registered location and carried out a desk top review of data the provider sent following the onsite inspection. We carried out telephone interviews with senior staff in the days following the onsite inspection.

On the day of the inspection we visited triage, antenatal clinic, post-natal ward, Larch ward, the maternity assessment unit, the maternity booking centre, the delivery suite and the midwifery led birthing centre. We spoke with 28 staff members including; service leads, matrons, midwives, doctors and midwifery care assistants. We looked at 10 sets of notes, 10 sets of medication charts and NEWS charts, reviewed a wide range of documents including; policies, meeting minutes, action plans, prescription charts, risk assessments and audit results.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- Not all staff adhered to the trust uniform policy.
- The medical leadership structure was not fully embedded with all medical staff and some staff were unsure of their responsibilities.
- Some staff were not given enough time to complete their specialist roles.
- Safety champions were not visible, and staff were not always aware of the safety champions role and responsibility.
- There was a lack of information available to women in languages other than English.
- There was a perceived culture of blame amongst some staff.

However:

- The senior leadership were visible and well received by all staff.
- The service managed serious incidents well with actions and learning disseminated to all staff.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- Staff collected safety information and shared it with staff, women and visitors.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations and planned care to meet the needs of local people.

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

Maternity

Requires Improvement  

Our rating of this service stayed the same.

- Not all staff were up to date with their mandatory training. Training compliance had fallen during the COVID-19 pandemic, but a plan was in place to improve this. However, the service generally made sure staff were competent for their roles.
- Some staff did not always feel respected, supported and valued by all managers. An open culture where all staff felt they could raise concerns without fear was not fully embedded with all staff.
- We were not assured that the medical leadership structure was fully embedded with all medical staff and found some staff were unsure of their responsibilities. Safety champions were not visible, and staff were not always aware of the safety champions role and responsibility.
- The psychological and emotional needs of women, their relatives and carers were not referred to during handover meetings.

However:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on the results of these assessments and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff felt respected, supported and valued. They were focused on the needs of women receiving care. Most staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement  

Mandatory training

The service provided mandatory training in key skills to all staff. However, compliance in training did not always meet the trust target.

Nursing and midwifery staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of women and staff.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training. We were told mandatory training which was delivered in person had been rescheduled due to pressures of the pandemic.

Medical staff received their mandatory training. We reviewed training data as of June 2021 and found there to be low compliance in basic life support training. Medical staff compliance was at 71%, which did not meet the trust target of 85%. Nursing and midwifery staff compliance to basic life support training fell below the trust target. We were told this was due to suspension of face to face training during the COVID-19 pandemic and adherence to government social distancing rules. On inspection we saw evidence staff were booked onto upcoming basic life support training. The trust target compliance would be met by the end of July 2021. Following inspection the service provided data which showed basic life support training had taken place and now met trust compliance. The service ensured that every shift had staff who were BLS compliant.

Medical staff had weekly CTG training and staff attended training by an external provider.

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

All staff reported the emphasis placed on mandatory updates and the value of the practice development team. The maternity support workers valued the support of the practice development midwives who worked with them and the preceptor midwives. The practice development midwives had produced workbooks to guide maternity support workers in their development and many were keen to progress to a midwifery apprenticeship.

Both student midwives and preceptee midwives stressed how having been students in the pandemic meant they had missed a large amount of clinical practice time and that sometimes the midwives forgot this. The practice development team supported this by introducing weekly reflection and learning sessions.

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.

Nursing and midwifery staff and medical staff received training specific for their role on how to recognise and report abuse. We reviewed training data and found as of June 2021 all eligible staff had received training in safeguarding adults level one and level two. There were three levels of safeguarding children training. All levels showed 95% of eligible staff had received training and safeguarding children level three was at or above the trust target of 85% in all clinical areas.

The service had a lead safeguarding midwife who had been proactive in developing a support group for complex women. There was a vulnerable women pathway which identified the most complex women and made sure antenatal care remained and women were offered additional care and support at planned care appointments. We saw evidence of effective relationships and improved engagement with vulnerable families. This included perinatal mental health and complex care cases.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They gave examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Maternity

We saw staff followed safe procedures for children visiting the ward. All babies were electronically tagged. Staff followed the baby abduction policy and undertook monthly baby abduction skills and drills exercises. All staff we spoke with were able to verify this and reference the last drills exercise.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Not all staff used equipment and control measures to protect women, themselves and others from infection. Staff kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw evidence that cleaning audits took place and action was taken to address the findings.

Cleaning schedules were up-to-date and demonstrated that all areas were cleaned regularly.

Not all staff followed infection control principles. We observed some staff who were not 'bare below the elbow'. This was not in line with the trust's uniform policy, nationally recognised guidance set out by National Institute for Health and Care Excellence (NICE) and posed a risk of cross infection.

All staff observed during the inspection wore a surgical mask in line with national guidance for COVID-19 and hand sanitiser was readily available for staff, patients and visitors to use. Dispensers were in all places, including outside every delivery room and all were full.

We saw good hand hygiene, and staff actively challenging visitors to clean their hands. Staff carried out weekly hand hygiene observations in every area to monitor standards. Hand hygiene audits shared with us showed 100% performance in all areas.

We observed staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Access to the maternity wards was via intercom or a swipe card and staff screened visitors to each ward before they were granted access. This prevented unauthorised access to the clinical areas.

Staff carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them to safely care for women and babies.

Emergency trolleys were checked twice a day and medicines and equipment were in date. Staff were allocated checking responsibilities daily and were required to record missing equipment and date of replacement. Resuscitation trolleys we checked during inspection had all been checked by breaking the seal to check equipment inside. There were separate emergency trolleys with equipment to manage postpartum haemorrhage. On inspection we found the postpartum haemorrhage trolley unlocked in the labour ward. On checking we found medication and equipment that should not have been in there. There was also a soiled piece of equipment. This was immediately rectified by staff and highlighted to management. Senior leadership told us this PPH trolley had just been used and staff had not yet checked and replenished stock. All other postpartum haemorrhage trolleys we checked were locked and medication and equipment matched the checklist.

Maternity

We saw staff responded quickly when women pressed the call bell.

The design of the environment followed national guidance. The birthing centre was located adjacent to the labour ward providing easy access for staff and when transferring women between clinical areas.

Triage was located on a different floor to labour ward. Staff told us the transfer time between these two locations had been identified as a risk. Medical staff we spoke with told us there was a delay in transfer of women to labour ward due to shortage of both staff and rooms. We were told that sometimes deliveries happened in triage due to a delay in getting them to labour ward. To address this, facilities were made as conducive and private as possible for women to labour.

At the time of our inspection there were planned building works being undertaken to adhere to fire safety. The environment in the antenatal clinic was deemed not fit for purpose and building works was underway this was integrated with the essential works to adhere to fire safety regulations. This meant some services had been relocated. However, all areas were signposted, and staff accompanied women when directing them to avoid any disruption. The maternity risk register stated the community midwifery estates were not fit for purpose and were being condemned. Senior staff told us there was an urgent requirement for interim or long-term estates to support midwifery community teams.

The service had suitable facilities to meet the needs of women's families. In the postnatal ward we observed an accessible food area for mothers and their families.

The service had good access to medical gases, and these were always replaced in a timely manner to ensure women and their babies had access to safe care.

Staff disposed of clinical waste safely. Staff had received training from the clinical waste team and there were posters in all sluices showing which container to use. We found bins ready for use in all clinical areas, and the small sharps bins on wards were attached to the wall. There was regular collection of full bins and new containers were assembled and labelled as soon as one was closed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The Maternity Early Obstetric Warning Scoring (MEOWS) system was in place and staff received training in its use. On inspection we viewed the MEOWS audit which showed most notes audited had been accurately scored.

Staff completed risk assessments for each woman on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff were supported by a complex care consultant midwife if any issues arose.

Women with more complicated pregnancies were offered a 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.

Maternity

To promote safe care and effective management the maternity service had a set-criteria for which women would be accepted in each clinical area and completed a range of risk assessments on admission or at their antenatal appointment to ensure they were cared for in the most suitable clinical area, during labour and post-delivery. These included risk assessments for women wishing to use the midwifery birthing unit.

Staff knew about and dealt with any specific risk issues. This included sepsis, VTE, falls and pressure ulcers.

Staff told us the cardiotocography (CTG) midwife attended the labour ward handover and reviewed all CTGs. We saw that buddies were assigned for 'fresh eyes' reviews and 'fresh eyes' being completed and reviewed electronically. 'Fresh eyes' is recommended by national guidance to ensure CTGs had been correctly interpreted and escalated if appropriate. The practice development midwifes conducted spot check audits. Any anomalies identified were escalated immediately and aided action plans for individual line managers.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff in the antenatal clinic we spoke with were aware of how to refer women for additional support and how to escalate concerns and access specialist midwives, for example to the mental health team via referral and a substance misuse midwife.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Staff shared key information to keep women safe when handing over their care to others. We saw evidence of this within patient notes and handover meetings. Shift changes and handovers included information to keep women and babies safe.

In line with Saving Babies Lives Care Bundle, 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. This was in line with national guidance RCOG: 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'.

The maternity service was compliant with Saving Babies' Lives Care Bundle Version 2 (SBLCB2). This care bundle brings together best practice and aims to reduce perinatal mortality.

All women who called the unit were triaged using an assessment tool, the findings of this assessment were recorded on a standard form and provided a record of the advice given, such as for the mother to come into hospital.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and midwifery staff to keep women and babies safe. On inspection we saw the maternity dashboard displayed a midwife to birth ratio of 1:25 and staff told us this increased to a 1:28 ratio at busy periods. This was in line with the recommended 1:28 Birthrate Plus safe staffing standard. Staff told us they still reported a shortfall to manage the activity of increased patient complexity.

Maternity

At the time of the inspection senior staff told us there were vacancies at band five and six. Prior to our inspection the Associate Director of Midwifery had left the trust for a new position, there was an interim Associate Director of Midwifery in place.

Discussions took place during handover and at the daily maternity safety huddle on the movement of staff and how best to allocate resources considering the acuity of women. An acuity tool called Birthrate plus was utilised every six hours.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance.

Maternity board meeting minutes from May 2021 highlighted there was a 17% vacancy rate in maternity. We saw vacancies advertised on NHS jobs. Data provided post inspection showed the service had reducing vacancy rates and a reduction from 31.7% to 11.2% in turnover of staff appointed in the last 12 months.

The ward manager could adjust staffing levels daily according to the needs of women. Staff told us in labour ward the case mix acuity was rising in most complex women being seen. We were told the delivery suite was occupied with complex labour inductions and postnatal women. Due to this there were always two band seven midwifes on duty. Data provided demonstrated the compliance of 1:1 care was 99.4%.

The number of midwives and healthcare assistants matched the planned numbers, and these were displayed within all areas.

The Newham women's and children's integrated performance report from May 2021 stated the total sickness in all areas of maternity was 15.74 WTE. This was a reduction from April 2021 data and senior leadership told us this was continuing to reduce as staff returned from shielding.

The annualised maternity sickness absence was at 2.89% which was lower than the trust target of 3%. Data provided by the trust showed two peaks in December 2020 and January 2021, which reflected national peaks.

The service utilised bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

Medical staff told us there were no gaps in the consultant or medical staff rota. However, on inspection we reviewed the rota for the week and saw there were gaps in the consultant rota which were covered by internal locums. We saw there were three days not covered in theatres for elective or emergency caesareans. When asked, some medical staff were unable to explain the gaps in rota or mitigation that had been put in place. Senior staff highlighted there was a rota gap at middle grade tier. After the inspection we held interviews with the senior leadership team and requested data. Data showed that gaps within the rota were always covered and mitigated against. We were told the rota we had viewed on site had been the draft document and the rota for the week of inspection was shared with us.

Maternity

Antenatal ward rounds were done by gynaecology on-call team. We were told this was because labour ward would be very busy needing senior presence most of the times. We were told the obstetrics team oversaw the labour ward. During safety huddles we observed minimal exchange of information between the gynaecology and obstetrics team. However, we saw evidence of communication between both teams in patient notes.

Staff told us there were difficulties during the COVID period due to staff sickness especially within the medical team. This had meant consultants had come off the on-call rota. With the reduction in work force the service reduced antenatal clinics and developed more virtual clinics.

The senior management team told us medical staffing numbers had been amended during the peak of the COVID -19 pandemic with staff redeployed across the hospital to support their peers.

We requested data for medical staff turnover and sickness, however this was not broken down by staff group and it was not clear the number of medical staff who were absent. However, the Newham Women's and Children's Integrated Performance Report from May 2021 detailed that two doctors were on sick leave; one speciality doctor was on long term and one consultant was on short term sick leave.

Managers told us they made sure locums had a full induction to the service before they started work. However, staff we spoke with were not always aware of systems and procedures. For example, some staff were not aware of who the safety champion was or how to escalate concerns or queries.

Although junior staff felt supported and supervised, some staff told us they would call a senior colleague at another trust for advice.

Where there were gaps in the consultant on-call rota, we saw that these were covered by an in-house locum.

Records

Staff mostly kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care.

A combination of paper based and electronic records were maintained for each woman that reflected the care and treatment she had received. All records were easily accessible and stored securely with paper records held in a locked trolley. Women's notes were comprehensive, and all staff could access them easily. When women transferred to a new team, there were no delays in staff accessing their records.

We reviewed a sample of ten medical records. All records we reviewed were signed and dated. Risk factors such as living in a deprived area, comorbidities and BMI were clearly documented to identify those most at risk. Records evidenced CTG records had 'fresh eyes' documented, which demonstrated CTGs had been reviewed by a second staff member. Documentation at the start/end and during CTG met NICE guidance and fetal movements and growth were recorded and plotted at each antenatal visit.

We saw that women had been asked about possible domestic abuse and had a mental health assessment. In eight medical records we saw individual specific information such as if they had vitamin D prescribed and if they had had their COVID vaccination.

We reviewed ten medication and observation charts and found poor compliance with documenting the weight of the patient. Staff we spoke with told us it would be usual to look at the patients' medical records to confirm the weight.

Maternity

On review of eight sets of neonatal observation charts, all were fully complete with demographic details, weight, full set of observations, correct scoring and signed. All maternity care assistants and midwifes we spoke with were able to describe the escalation process if anomalies in the charts had been observed.

Medicines

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

We checked medication storage rooms on labour and the postnatal ward. Both were locked and accessible by key card only. The rooms were clean and uncluttered with all cupboards locked. We saw all cupboards were labelled for contents.

We observed there to be no available monographs for antibiotic administrations. Staff informed us they would use the BNF to ensure antibiotics were made up correctly and that there were no interactions with other medications/ antibiotics if they were unsure. We were told a pharmacist visited the wards regularly to check drug charts and ward stocks. Staff told us drug charts marked with green pen showed the pharmacist had reviewed them. However, we did not see any evidence of green markings on the charts we checked.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Allergies were clearly documented; however, the patient's weight was not always documented within the medication chart.

We did not see evidence individuals and teams responsible for antimicrobial stewardship had monitored data and provided feedback on prescribing practice to prescriber level.

Incidents

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

All staff knew how to report incidents and felt confident to do so. The incident and serious incident policy was in date, reflected national guidance and had a suitable review date.

We were assured all staff understood duty of candour which meant women and their families would be given a full explanation if things went wrong. Staff told us duty of candour was applied to all incidents. This was in line with the trust's incident and serious incident policy which states duty of candour should be applied when there has been a notifiable incident.

Although staff raised concerns and reported incidents and near misses in line with trust policy, a small group of staff we spoke with expressed reluctance in escalating clinical and operational issues. Some staff stated there was a blame culture around incidents and feared reprisal. However, most staff we spoke with told us managers were supportive and encouraged staff to report incidents. All staff we spoke with stated that incidents were better managed with the introduction of the new leadership team.

The service had a governance lead midwife in post who led a daily incident meeting. This meeting was attended by clinical leads and midwifery managers. At this meeting we saw that clinical activities, staffing and capacity were

reviewed. The unit was RAG rated according to these factors and the rating agreed as a team. All incident reports from the last 24 hours were discussed and immediate learning to support changes if required. We were told that at the weekend an on-call manager would review the status of the maternity unit. We saw at this meeting all attendees were encouraged to discuss and challenge and observed a culture of shared governance.

Governance and governance practice development midwives were responsible for implementing learning from actions. Prior to our inspection we reviewed data which highlighted a cluster of pressure sores related to epidural given with motor block leading to less mobility in labouring women. Staff told us that actions to address this included implementing MDT training with an anaesthetist and introducing the use of pressure area risk assessments for use with epidural/spinal anaesthesia. On inspection we saw completed pressure area risk assessments in notes we reviewed.

Data seen prior to the inspection highlighted there had been never events relating to retained swabs. We saw evidence of a full review including actions and the development of Local Safety Standards for Invasive Procedures (LocSSIPs) within delivery rooms. The service had engaged with the supplier to implement new birthing packs. Staff developed a LocSSIP together for use in birthing rooms. To support the implementation of the LocSSIP an additional member of staff worked within the delivery suite. Staff told us the birthing packs no longer contained swabs. However, on inspection we found swabs were still within birthing packs. When we highlighted this to senior management action was taken immediately to rectify this. Post inspection the trust sent us assurance that birthing packs no longer contained swabs.

Staff received feedback on the types of incidents that had been reported via a newsletter. The service had developed a web platform for information sharing and learning as senior leadership had identified communications to all team members as a big challenge. Some medical staff stated they did not read these newsletters due to time constraints.

Managers debriefed and supported staff after any serious incident. The divisional director told us they provided support to staff following an incident. A debrief was held the following day and they would approach staff periodically to check on them. The service had Professional Midwifery Advocates (PMAs) who were available for staff to speak with at all times.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The hospital collected data and made returns for the national maternity safety thermometer. The postnatal ward displayed safety data on staffing, falls, pressure ulcers and MRSA using the safety cross system.

Staff used the safety thermometer data to further improve services.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same.

Evidence-based care and treatment

The service provided care and treatment based on updated national guidance and evidence based practice.

Maternity

Staff we spoke with knew how to access policies and guidance on the trust intranet.

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).

Medical staff told us the trust post-partum haemorrhage (PPH) guidelines were still being reviewed across sites and there was a delay in completion of guidelines. The service used up to date local PPH guidelines which reflected national guidance. To ensure consistency across all Barts maternity location the guideline was in the process of being streamlined. Staff were unable to provide information on timelines for completion.

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 peri health care bundle for perineal trauma in childbirth.

The service had introduced consultant midwife-led Birth Options and Birth Reflections clinics and had a digital midwife in place. The main role of a digital midwife was to lead the way in which the service uses technology to enhance the care given to women and improve outcomes for mothers and their babies.

We saw evidence of an embedded audit schedule and all audits were completed and up to date.

The service was in the process of implementing a patient group direction (PGD) to allow midwives to offer codeine to women delivering in the birthing centre. This was in response to some women not being prescribed codeine in a timely manner.

The trust was working towards achieving stage 3 of the UNICEF UK Baby Friendly Initiative, which is about infant feeding and relationship-building within new families.

Mental health assessments were generally well completed. We reviewed 10 records and found in eight episodes of care a mental health assessment had been undertaken using the nationally recommended 'Whooley' questions. However, at handover meetings we attended, staff did not routinely refer to the psychological and emotional needs of women, their relatives and carers.

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.

Managers made sure staff received any specialist training for their role. However, during the pandemic face to face training sessions had been put on hold with virtual Practical Obstetric Multi-Professional Training (PROMPT) sessions being provided.

We were told the maternity service would be submitting compliance with all ten safety standards of the Clinical Negligence Scheme for Trusts (CNST). Senior management told us the most challenging areas for the Trust were: safety action 1 – use of PMRT (Perinatal Mortality Review Tool) and the ability to undertake this in time frame and safety action 6 which relates to compliance with mandatory training. Staff told us the revised guidance had helped by removing the compliance levels. We saw an action plan to address training recovery from COVID-19, with an improvement trajectory for the coming year.

Maternity

Staff had not rotated to other areas of the maternity service for three years. Management told us staff were due to rotate in September 2021. Some staff we spoke with stated they were anxious about the pending rotation. Management told us there had been engagement with staff and it was decided that rotation would be implemented in stages. The rotation would allow midwives to develop their skills and experience in all areas. The practice development team were preparing for the additional support and upskilling that would be required to support staff.

All staff had the opportunity to participate in appraisals. We were told during the pandemic staff appraisals had been suspended and therefore the maternity service had not met their target for staff appraisals. On inspection staff told us they would be having their appraisal in the coming weeks. Data seen on inspection showed that in May 2021 89.8% of medical staff had received an appraisal. Within neonatal 95% of non-medical appraisals had been completed, however, the maternity non-medical appraisal compliance was at 66%. We saw evidence that the senior team were working towards completion by the end of June 2021. Senior staff told us the low appraisal compliance was due to new staff, staff on long term sick leave or maternity leave.

Staff were able to access further training and development and were supported by their managers to do so. Those staff we spoke with told us they had been encouraged to attend further training to develop their careers with some being provided with time out from their clinical roles to complete this. The service implemented career clinics to support fellowship pathways for staff. The practice development team supported staff and were instrumental in setting up training sessions.

Multidisciplinary working

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

The service held multidisciplinary team (MDT) handovers twice a day to discuss women and improve their care. We noted that all members of the team contributed to discussions and women requiring urgent reviews were flagged and plans made to involve and consult with other professionals not in attendance were made.

Specialist midwives, such as the specialist diabetic midwife, were available to provide holistic care for women. However, staff told us specialist midwives were often deployed to work in other areas to provide cover. This meant that specialist midwives may not be able to undertake their specific roles or be readily available to provide specialist advice. Staff of all disciplines told us that “teamwork was really good” and there was a cohesive team. Staff said that members of the MDT were comfortable to professionally challenge each other

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, there was a lack of clear structure among the medical leadership.

Maternity

The maternity service was managed through the trust's women's and children division. The senior leadership team comprised of a divisional director of women, children's and outpatients, a divisional manager of women children's and outpatients and a clinical director of obstetrics and gynaecology.

Prior to our inspection the associate director of midwifery had left the service and on inspection, we saw there was an interim director in post who was supported by the deputy head of midwifery.

Leaders were aware of the challenges the service faced. All staff we spoke with stated they were visible and supportive. We saw timely action was taken to address concerns identified within the service. The head of midwifery reported to the chief nurse who reported maternity feedback to board.

The leadership triumvirate met on a weekly basis to discuss operational issues, complaints, serious incidents and mitigating actions. Additionally, there was a daily risk review meeting attended by governance lead, band seven bleep holder and other clinical and non-clinical midwifery leads. We attended the daily meeting. However, there was no agenda and no minutes were taken. This meant that themes could not be clearly identified, nor actions taken audited to ensure any relevant changes in practice were made.

Medical staff we spoke with stated there were a lot of management meetings which caused difficulty for clinical leads to undertake ward rounds in labour ward. Staff told us there was a disconnect between the management team and consultants working on the shop floor.

We found there was no clear medical leadership structure. There was a lack of clear roles and responsibilities among consultants. Some locum consultants we spoke with had many roles and responsibilities but stated they were not always adequately supported and would seek advice from colleagues at another hospital if they had a query. However, we saw records of one to one conversations with the medical leadership team.

We were told there was no safety champion amongst the consultants. However, in further interviews with the senior medical team we were able to identify the safety champion. Senior leadership told us the visibility of safety champions and communication intelligence from floor to board was not as visible as it should be for staff to know who the safety champions are. Some staff we spoke with confirmed in their interviews that they did not know who the safety champions were, but that they would escalate any concerns to their line manager.

The service had a practice development team who we noted as being cohesive, motivated and clinically knowledgeable. They supported midwives in their clinical practice.

Culture

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

All staff spoken with independently reported that it was a good place to work and felt like 'family'.

Staff said that they felt well supported by their line manager and would go and talk to them if they had safety concerns, they clarified that by line manager they meant the ward sister. Some junior midwives were unsure if they would access more senior management. Staff described that that they had had previous negative experiences when escalating to more senior staff. It was noted by some junior staff that staff above ward sister were not always visible at busy periods after 17:00.

Maternity

Following the inspection, we requested the NHS staff survey results from 2020. We saw that 41% of midwife led maternity staff would recommend the organisation as a place to work. This had reduced from 63% in 2019. Leadership were aware of the low staff morale from workforce consultations and actions had been put in place to address this.

Staff had a dedicated wellbeing space with had coffee machines, pamper boxes, which was well received by all staff. Staff we spoke with valued the visibility of the DoM and the 'hands on' approach to supporting staff. During the peak of the COVID-19 pandemic staff told us management operated an open-door policy and had weekly discussions with cake rounds. In response to the COVID-19 pandemic the service introduced staff reflect and reset engagement sessions.

Some junior staff shared that they had received different responses in support from different clinical areas. They reported an 'exclusive' culture within the birthing centre where staff were not made to feel welcome. In contrast, staff told us the delivery suite and postnatal ward felt more inclusive when junior staff were made to feel a part of the 'family'.

On inspection, we saw there was a divide amongst staff due to long term friendship groups, senior leadership confirmed this and stated that this sometimes affected behavior on a shift basis. Leadership shared their actions to address this, which involved implementing culture programmes such as a wellbeing works assessment and focus groups facilitated by the Birmingham Race Action Partnership (BRAP). BRAP is an equality and human rights based advisory organisation who provide a progressive and evidence-based approach to mitigating inequality and discrimination.

Senior leadership recognised there were leadership capability issues at band 7 and 8a level particularly related to the perception of lack of support and the inability to have difficult conversations. We were told about the service's action plan which was to address leadership and management development. An assessment centre and development programmes had been put in place and matrons had been enrolled onto an external management course.

The service had a maternity voices partnership (MVP) which is an NHS working group independently chaired to help develop local maternity care. The two co-chairs were appointed during the ongoing pandemic and as a result have only been able to visit the service once. They told us they had good working relationships with staff and were beginning to connect with users of the service via social media platforms. Senior staff told us they valued the role of the MVP and their help in capturing the voice of users of the service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Majority of staff 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 most staff were clear about their roles and understood their responsibilities. We found some gaps in operational knowledge when speaking with some medical staff. 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 maternity board meeting minutes for March, April and May 2021 and found there was consistency in the format and structure of these meetings. The meeting agenda included discussion on minutes and actions from the last meeting, caesarean sections, quality assurance report tool, 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.

Maternity

We reviewed the women's and children's integrated performance report from April and May 2021 where we saw a detailed review of the risk register, maternity dashboard, neonatal dashboard, action log, 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 Barts Health NHS Trust. We reviewed the minutes for April and May 2021 and found there was consistency in the format and structure of these meetings. The minutes showed the cross-site director of midwifery attended alongside representation from the other hospital sites. Staff told us the learning from cross sites incidents was shared through daily safety huddles and newsletters.

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. We saw a public facing maternity dashboard poster displayed within service areas. Maternity dashboard data was formatted in an easy to read style so women and their family were aware of the services performance.

We saw a governance board in the staff room and ward areas, this displayed all information about top risk, updated incidents, PALS & complaints, reminders of new practice changes, safety expectations, such as Information governance, number of births, good practice points; reminders such as risk assessments and pressure care plans and Birthrate plus compliance of one to one care in labour. This was updated every Tuesday by the governance practice development midwife.

Staff told us that the senior leads and senior midwives were visible and walked around each maternity area checking for cleanliness, equipment checks and emergency medicines trolleys. The maternity service kept staff up to date through several newsletters such as the weekly risk management governance update. As well as an update of complaints, top five incidents and investigations and reports the weekly newsletter included a case presentation highlighting learning outcomes.

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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks on the register 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.

Senior leaders and managers of the maternity service had an understanding of risks to the service and these were appropriately documented in risk management documentation. We saw that risks identified on inspection were on the risk register. This included antenatal clinic environment and community midwifery estates which were not fit for purpose. Works were underway and sat at board level for oversight and monitoring.

Maternity

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. We saw the dashboard was displayed in some clinical areas, this meant that staff were informed of the outcomes and risks of the maternity service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated but not always secure. Data or notifications were consistently submitted to external organisations as required.

Arrangements were in place to ensure confidentiality of maternity patient records was robust. We found the trolleys and filing cabinets where patient records were stored at the midwives' station were lockable. Information governance was discussed at every midwifery handover with a reminder to lock computer screens reiterated. On Larch ward, we saw a computer was left unattended with patient details still visible. Senior leadership immediately actioned this and spoke with the staff member concerned. All other computer screens we saw were closed when not attended. Staff had password access to electronic systems

Data or notifications were submitted to external organisations as required. The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). This enabled the service to benchmark performance against other providers and national outcomes.

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.

The staff survey results completed in November 2020 highlighted maternity and gynaecology as areas of concern within the service. The senior leadership team conducted a local review following the survey results and stated a different perspective was seen. In April 2021, focus groups were held across the division to see if the results from the survey still resonated with staff. Staff relayed to leaders that things still needed to change and there were discussions about pre-COVID. The senior leadership team (SLT) told us feedback from focus groups was mainly around challenging staff behaviour.

The SLT told us an external company had administered a survey to look at staff wellbeing and psychological safety. The SLT told us the results would be available in July 2021 and a follow up survey would run in September 2021.

The service captured FFT data for all the maternity areas including the community. Feedback was also collected through social media forums. The service had introduced a women's experience midwife which had reduced complaints and improved issues with staff behaviours and attitudes. The SLT told us a feasibility case to continue funding this role had been written.

Maternity

We saw data which showed 84.5% of women spoken to by the women experience midwife had reported being happy with the service. This remained consistent since December 2020. In May 2021 83 FFT forms were submitted with 96% of patients happy with the service.

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).

We saw that there was an online women forum set up where women could ask questions. A Black, Asian and minority ethnic (BAME) women's support group had been implemented which meant complex women were in a caseload team and would receive continuity of care.

In order to address the four actions of the Chief Midwifery Officer (CMO) to support BAME women and women living in deprived areas during the pandemic the service had increased support of at-risk pregnant women by making sure clinicians had a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background. The service had reached out and reassured pregnant BAME women with tailored communications.

The service recorded on maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes. Most of the Newham case mix fell into these groups and despite the birth-rate falling across London Newham birth numbers had risen with women choosing to birth there.

All four recommendations built into the CMO letter of June 2020 were implemented as they applied to a high number of the Newham case mix. The service implemented change to the online referral to ensure ethnicity was captured to support provision of vitamin D.

The community care team delivered a 75% universal offer in a caseload of 85% black, Asian, minority ethnic and socially deprived families. There was ongoing work to ensure that a wider range of vitamins were available to all women in pregnancy. Additional pregnancy sessions were available for at risk women particularly around birth choices. This included birth reflection and birth trauma rewind services. There was a cost pressure to staff this, however deemed this appropriate for their local population.

An additional Continuity of Carer Team was set up during the COVID-19 pandemic to meet the increased needs of this group of women. It was an inclusive pathway for all women who met the criteria and was not postcode based. The SLT told us the patient feedback received had been positive but recognised further audit was required to assess the clinical effectiveness of this care pathway.

On inspection we did not see written information in any other languages except English. The SLT told us there was information available and provided to women in the top languages. Discharge books both antenatally and postnatally were provided in other languages. The SLT told us work was ongoing with the LMS to source more information in different languages. The SLT acknowledged that there was not a lot of visible information available to women in different languages, but they felt women knew from onset of pregnancy that interpretation services were available, and information could be accessed for them in different languages. Continuity teams had improved the experience of these women as evidenced in feedback from women.

The service had 24/7 use of a video interpretation service, this was available via an app and also on android services.

Maternity

Learning, continuous improvement and innovation

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

The maternity service was involved in quality improvement (QI) programmes which included process mapping and patient experience. For example, during the COVID-19 pandemic there was a QI programme which introduced virtual zoom classes to prepare women for induction of labour. This was held weekly to manage expectations. Staff told us they still needed to evaluate this, but initial observations were positive as women were better prepared for induction of labour. The service also offered a birth reflection service to all women who requested it.

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 9% and the service was aiming for greater than this by the end of the quarter.

Outstanding practice

Maternity services had improved its contact with the public. Newham maternity unit was the first in Barts Health to take part in a maternity experience communication event designed for staff of all disciplines to understand the patient experience. This event was called 'whose shoes' and centred around an engaging board game and encouraged everyone to walk in other people's shoes and understand the service users, carers and staff experience.

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 started a second caseload team during the COVID-19 pandemic to meet the BAME agenda. This was inclusive of all women with most complex needs and was not postcode specific.

The service had introduced a womens' experience midwife which led to a reduction in complaints and improved staff behaviours and attitudes.

Areas for improvement

SHOULDS

Maternity service

- The service should ensure compliance of basic life support training meets the trust target.
- The service should consider staff adhere to the trust uniform policy.
- The service should continue to ensure all emergency and PPH trolleys are checked regularly and locked.
- The service should continue to ensure that interim or long-term estates are prioritised on the risk register to support the midwifery community team.
- The service should ensure the medical leadership structure is fully embedded and that all medical staff are aware.

Maternity

- The service should ensure the psychological and emotional needs of women, their relatives and carers are referred to during handover meetings.
- The service should continue to ensure the birthing packs do not contain swabs.
- The service should ensure all drug charts checked by the pharmacist team are clearly documented and audited.
- The service should ensure teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice to prescriber level.
- The service should ensure specialist midwifes are supported and allowed time to fulfil their role.
- The service should ensure information is made available to women in languages other than English.
- The service should ensure that safety champions are visible and ensure all staff are aware of the safety champions roles and responsibilities.
- The service should ensure all computers remain locked when unattended.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist CQC advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.