Barts Health NHS Trust

The Royal London Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at The Royal London Hospital

Requires Improvement 

We inspected the Maternity service at The Royal London Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the Maternity service on the 17th of August 2022, looking only at the safe and well led key questions.

Bart's Health NHS Trust provide maternity services from five locations these are the Whipps Cross University Hospital, The Royal London Hospital, Newham University Hospital and two standalone birth centres The Barkantine and Barking birth centre.

The Royal London Hospital is in the heart of Whitechapel London. Services are aimed at a diverse population with areas of social deprivation and included antenatal, fetal medicine, consultant led labour ward and the Lotus birth centre, postnatal and community midwifery services to the local population. From August 2021 to July 2022 there were 5,140 babies born at the hospital.

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

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

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

Whipps Cross University Hospital – http://www.cqc.org.uk/location/R1HKH

Our rating of this hospital went down. We rated it as requires improvement because:

- Our ratings of the Maternity service changed the ratings for the Royal London Hospital overall. We rated safe as requires improvement and well-led as requires improvement and the Royal London as requires improvement.

Maternity

Requires Improvement

Our rating of this core service went down. We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe. Staff did not always complete accurate risk assessments for women or keep good care records. Not all incidents were appropriately reviewed or accurately graded. Safeguarding training rates fell below trust targets for clinical staff. Infection prevention control measures and training fell below trust targets.
- There was not enough vital newborn resuscitaire lifesaving equipment in every labour room. There was no centralised CTG monitoring. There were times when the service did not have a band 7 supernumerary shift co-ordinator this does not confirm to national standards. Medication was not managed safely we found unlocked cupboards and medication fridges, and medication stored in stock rooms. Patient records were not always stored safely during busy periods we saw numerous care records left unattended.
- Changes to the leadership team had led to gaps in governance processes, the service did not have reliable information systems, records were not stored safely. The workforce strategy was ineffective. Risk was not always managed well. Staff were not supported to develop their skills due to workload pressure. The service did not have a clear vision. Workload pressure meant that not all staff felt respected, supported, and valued.

However:

- Most staff received mandatory training in key skills and multi-professional obstetric simulated emergency training. Safeguarding systems protected mothers and babies from abuse. Staff worked hard to maintain services and care for women, despite additional pressures and busy workloads. They were focused on the needs of women receiving care.
- Staff were clear about their roles and accountabilities most of the time. Managers monitored the effectiveness of the service.
- The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. and all staff were committed to improving services continually.
- The new leadership team were in the process of implementing a new strategy that reflected the needs of a diverse high risk population. They understood the challenges of the services and implemented workstreams to improve consistency in care and governance processes.

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff and however compliance rates were not consistent throughout maternity.

Maternity

Staff received and kept up-to-date with their mandatory training. Practice development midwives and clinical assessors monitored training compliance. Records showed some areas of maternity performed better than others. For example, 87% on labour ward staff completed their training but only 77% of antenatal clinic staff had completed training. Overall, 83% of maternity staff had completed their mandatory training this was below the trust target of 85%.

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

Core skills training was delivered online and included but was not limited to, conflict resolution, fire safety, infection and prevention control, information governance and preventing radicalisation. Records showed staff compliance to the modules varied. For example, 85% of staff had completed conflict resolution but only 60% had completed infection prevention control training. Staff told us that they rarely had time to complete the online E-learning modules. Managers told us they were considering the offer of bank payment for staff who completed the training at home.

Staff attendance to basic life support training did not meet trust targets. Records showed overall maternity fell short of trust targets at 64%. This meant that over a third of the clinical workforce were not trained or up to date.

Staff received multi-professional obstetric simulated emergency training, which included neonatal life support but there was no evidence that human factors training was included. After the inspection time frame leaders provided evidence that human factors training was included in the September 2022 programme. Compliance varied across maternity for example 100% of midwives and 81% of doctors working and 80% of anaesthetic staff on labour ward were compliant.

Clinical staff received training to interpret and categorise cardiotocograph (CTG) results. Training was delivered annually and included an assessment. Completion rates varied for example, 100% of labour ward midwives were compliant, but only 69% of antenatal clinic midwives and 60% of specialist midwives had completed this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Practice development leads and managers monitored compliance by reviewing non complaint staff with their line managers. Leaders discussed completion rates at site level performance reviews.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse most of the time. Admin and clerical staff were trained at level 1 and 2 Safeguarding adults and children, and records confirmed training met trust targets. National guidelines state that staff who plan care must be trained at level 3 safeguarding. Records showed level 3 compliance rates did not meet trust targets. Only 68% of doctors and 74% of midwives were trained to the required level.

Leaders told us that level 3 rates were low due to a backlog created by Covid-19 and confusion around online and virtual sessions. Because level 3 training should be delivered face to face.

The named midwife for safeguarding contacted non-compliant staff and their managers to offer support and advice and explore time frames for compliance. The safeguarding lead understood the complexities of the hospitals diverse population. They reviewed safeguarding referrals, provided a link to external integrated care systems, and facilitated training and safeguarding supervision for staff, and they managed the specialist midwife for safeguarding.

Maternity

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Safeguarding training was delivered by the named midwife for safeguarding and included training on significant mental illness, learning and physical disabilities and records confirmed this.

Safeguarding and perinatal services worked collaboratively. The named midwife for safeguarding worked closely with the specialist midwife for perinatal mental health. Both were passionate about the services provided at The Royal London Hospital and the neighbouring integrated care systems. The perinatal mental health midwife had built good relationships with the local authority and the local NHS mental health trust and attended weekly clinical meetings. They worked together to produce a crisis pathway for women.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. The hospital had invested in barcode system on notes that women could scan if they needed help with domestic violence, trafficking or sexual slavery.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a vulnerable women's continuity of care team for women at higher risk of abuse or mental illness.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff accessed referral forms online. Staff uploaded completed referrals to a central system and notified the named midwife for safeguarding who planned to respond within 48 hours.

Staff followed a 'did not attend' standard operating procedure for women who did not attend planned appointments more than once.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff had access to electronic tagging of babies. Ward doors were locked and were operated by a buzzer system. However, during the inspection we asked for the results of the most recent baby abduction drill and the trust was unable to provide this in addition staff were unable to articulate when the last baby abduction drill had taken place. During the factual accuracy process the inspection leaders showed us evidence of a mock abduction simulated drill, but it did not contain the details of staff who were involved in the drill.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained most of the time. Maternity services had systems to keep areas clean and free from infection and monitored their effectiveness.

The service performance for cleanliness failed to meet trust targets from April to August 2022. Records showed the trust monitored staff compliance to infection control and produced detailed quarterly reports. The infection prevention control practitioner visited all areas of maternity and inspected areas and completed an observational audit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly most of the time. House keepers were visible and supported midwives in keeping most areas clear However, by lunchtime the triage area had become disorganised because of the volume of women attending the unit and the reception area was cluttered.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff in all areas wore masks, and hand sanitiser was available at workstations and at the entrance to ward areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During the inspection we noted that I am clean stickers were not clearly sited on all equipment at the start of the shift.

Managers monitored nosocomial rates within the service and records showed most of the time the trust performed well for hospital acquired infections. Records showed there had been several cases of infection acquired via intravenous access equipment. Also, the service had recorded a red flag for E-coli in June 2022.

Managers discussed lapses in infection prevention control (IPC) at safety huddles and team talks and had a named link infection prevention control midwife. However, records showed training compliance for IPC fell short of the trusts target at 60%.

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.

Women could reach call bells, however, due to staffing issues staff could not always respond quickly. Staff showed women how to use call buzzers when they were admitted to the ward.

The design of the environment followed national guidance. The maternity unit and co-located birth centre were situated on the 6th and 8th floor of the hospital and could be accessed by lifts. Access by stairs required swipe card access. The antenatal clinic was on the 8th floor and was difficult to access for heavily pregnant women when the lifts were busy. Also, we noted that it was poorly sign posted

Obstetric theatres were accessed via the labour ward they were well equipped, and staff completed daily checks on equipment.

Staff did not have access to all the emergency equipment needed to provide safe care. For example, we saw not all labour rooms had a CTG monitor or a resuscitaire. Leaders submitted a business plan for more although there was no time frame for purchase. However, during the factual accuracy process the trust informed there they had 16 CTGs in use on the labour ward for their eight delivery rooms. Lack of resuscitation equipment for newborn life support could have a negative impact on outcomes. Also, we found that not all clinical rooms had locks. We found that this was a known risk on the trust risk register. Because of this we were able to access a clinical room unsupervised where we found fetal remains stored in an unlocked fridge. We raised this with leaders who responded immediately by having a lock installed on the fridge. However, they told us that they had been waiting for swipe card access to rooms for some time.

Staff carried out daily safety checks of specialist equipment most of the time. Leaders allocated staff to check specialist equipment at handovers. Checklists were available on each piece of equipment. However, the checklist on the resuscitaire (a piece of equipment used to support neonatal resuscitation) in the triage corridor confirmed it had only been checked twice in August 2022.

The service had suitable facilities to meet the needs of women's families. Leaders planned to reconfigure the layout of maternity triage because its current location could not support the volume of women who arrived unannounced at triage. The area was not private and there were only four rooms, one had been divided into two and one had been a birthing room and included a plumbed in birth pool.

Maternity

The service had enough suitable equipment to help them to safely care for women and babies. Staff had access to suitable equipment, to complete maternal observations, for example blood pressure and heart rate monitors and access to an ultrasound scanner.

Staff disposed of clinical waste safely. Colour coded clinical waste and sharps bins were available and accessible in all areas. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff did not always complete and updated risk assessments for each woman and take action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used nationally recognised tools to identify women at risk of deterioration and escalated them appropriately at each point of care most of the time. Staff used various tools to identify women at risk of deterioration throughout their pregnancy and during childbirth. However, we found that personalised care and support plans audits identified the service needed to make improvements to increase the quality of risk assessments.

Managers did not monitor waiting times effectively to ensure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff in triage recorded the mothers time of arrival most of the time. However, we saw examples of women arriving at triage when the service was busy, where staff asked them what their concern was and then told them to take a seat without recording the arrival time.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. During the booking risk assessment staff asked women a set of national standardised questions to identify those women most at risk of deliberate self-harm. Women identified as needing extra support were referred to the perinatal mental health team.

Staff completed risk assessments for each woman on admission / arrival, using recognised tools, and reviewed this regularly, including after any incident most of the time. Staff used various tools to assess and plan care throughout pregnancy, childbirth and during the postnatal period and reviewed these regularly most of the time. However, staff caring for women in triage did not have access to a triage standard operating procedure because the hospital was in the process of changing the triage process. Staff completed telephone risk assessments which were recorded in a triage telephone log

Staff in antenatal completed all pregnancy booking risk assessments when women first accessed the service and recorded care in women's handheld notes and uploaded the information via digital software. However, we reviewed eight sets of medical records, which did not state the identified risk at booking. This did not conform to national guidelines.

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

- Reducing smoking in pregnancy
- Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)

Maternity

- Effective fetal monitoring during labour
- Reducing preterm birth

Staff plotted fetal growth on 'Gap Grow' charts and records showed the charts were available in-patient notes. However, a review of the trust Perinatal Mortality Review Tool (PMRT) showed trust wide current the Gap Grow care pathway did not conform to national guidelines. Leaders cited capacity and staff habits for scans not being completed on time or recorded correctly. There was a timeline agreed to review the guidelines when the Royal college of obstetricians and gynaecologists publish their new guidelines which was anticipated to be six months following our inspection. At the time of our inspection there were no mitigations in place to ensure women were appropriately assessed.

Staff in triage did not use a consistent approach to assessing risk. The service had not implemented a maternity triage tool. Staff had access to a RAG (Red-Amber-Green) traffic light care bundle, however, were not trained to use it effectively and did not complete the recommendations section. However, managers told us that they planned to implement a national triage system and were working with staff in the accident and emergency triage department to make sure the process was robust, and women could safely flow through the system. Although, there was no time frame for implementation.

Staff completed the Modified Early Obstetric Warning Score (MEOWS) assessments when caring for women on the maternity unit. The MEOWS charts were clear and identified women who were deteriorating, midwives escalated findings to doctors for review. However, there were times when reviews were delayed due to capacity and medical and midwifery staffing issues.

Staff knew about and dealt with any specific risk issues.

Staff followed an induction of labour standard operating procedure to care for women who required interventions to start labour. Women were cared for on the antenatal ward next to triage, where midwives completed admission risk assessments to establish which interventions were needed.

Staff monitored fetal wellbeing using a cardiotocograph (CTG) machine. Staff used a fresh eyes approach to review CTG progress, and the trust had appointed a fetal wellbeing midwife to support staff training and decision making. However, centralised CTG monitoring was not available at the trust, which was recommendation 10 of the Ockenden reports 'Immediate Essential Actions' (2022). Staff expressed concerns that the trust was not moving fast enough to address this issue as this feature of care would improve oversight and safety.

Staff completed venous thromboembolism (VTE) risk assessments on all women attending for care and during labour and record these on the electronic patient record.

Women attending the service for an elective caesarean attended a pre-assessment clinic, where staff completed a full risk assessment and gave women advice and medication prior to admission.

Staff used a maternal sepsis care bundle to identify women at risk of sepsis. The trust flagged as an outlier for puerperal sepsis on four occasions (from Jul 2019 to Sep 2021) via national data submission. Because of this, managers made improvements to practice, staff had access to a sepsis six bundle which included a screening and action tool and a colour coded clearly labelled trolley which contained the equipment and medication required to reduce poor outcomes and help women recover quickly.

Maternity

Staff in theatres made sure that the World Health Organisation (WHO) safer surgery checklist was completed, and leaders monitored compliance. Theatre staff attended team briefings prior to surgery and were given time to review complex cases.

The service had access to high dependency unit (HDU) for women's who condition deteriorated during labour most of the time. Midwives caring for HDU women had access to monitoring equipment, assessment forms, MEOWS, and the appropriate emergency medication.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. The service had a continuity of care team for vulnerable women and staff followed an inclusion criteria to make referrals to the team. Midwives used a multi-professional approach to provide specialist care for these mothers.

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 followed the services 'mental health crisis' pathway to escalate concerns in a timely manner.

Staff shared key information to keep women safe when handing over their care to others. Staff used a SBAR (situation, background, assessment, and recommendation) tool to plan assess and handover care to different departments. However, records showed that staff rarely completed the assessment and recommendation aspect of the tool. This meant that staff taking over care were not fully informed of the recommendations for future care.

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

Shift coordinators led daily MDT staffing huddles on labour ward, attendees included staff from all areas. Staffing across the unit was reviewed. There were opportunities for staff to ask questions and managers discussed current risks on the service. However, we noted a lack of leaders present at handover, for example consultants and matrons.

Staff did not use a Red Amber Green (RAG) rated newborn risk assessment to identify babies at risk of poor outcomes. Staff used various care bundles for babies who required additional observations. For example, prolonged rupture of membranes, and substance misuse scoring sheets and recorded observations on neonatal early warning scores for high-risk babies. This meant there were several documents to complete instead of one overall care plan.

The service had a transitional care service on the postnatal ward for babies who needed additional care in line with the 'Avoiding Term Admissions into Neonatal units Programme' (ATAIN).

Women suffering a bereavement were cared for in a self-contained room on the periphery of labour ward near women who were in childbirth. The room was also used for numerous reasons including external cephalic version (ECV), which was not in line with national recommendations.

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Maternity

The service did not have enough midwifery staff to keep women and babies safe. Records showed that the service had a high vacancy rates for doctors and midwives. We saw for July 2022 there was a shortfall of staff 58 whole time midwives. The shortfall reflected the national picture in terms of midwifery staffing.

The service report 134 incidents related to staffing from the 18 February to 16 August 2022, records showed that 34 of these incident caused delays in care.

Staff told us that the unit was often understaffed and felt dangerous. Lack of staffing had a negative impact on education, clinical duties, and staff morale.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance most of the time. Leaders used a national staffing acuity tool to calculate staffing needs and generated monthly reports on current staffing levels. The most recent report the hospitals establishment had been increased by 9.8 whole time equivalent staff posts in July 2022.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women. The service had a mixture of experienced and new staff. However, there was not always a supernummery shift co-ordinator on labour ward to ensure staff were well supported and care was safe. During the factual accuracy process the service provided evidence that in July 2022 there was 16 occasions where the shift coordinator was not supernummery. This is one of the Clinical Negligence Scheme for Trusts (CNST) 10 minimum standards.

The ward adjusted staffing levels daily according to the needs of women. Ward managers attended a daily staffing huddle where staffing across the unit was reviewed so that staff were deployed to the area's most in need. Managers reviewed the staffing acuity tool every four hours.

The number of midwives and healthcare assistants rarely matched the planned numbers. The service workforce planning report for July 2022 showed planned numbers rarely matched actual numbers of staff. There were big gaps in midwifery staffing on the postnatal ward and labour ward. Figures provided by the trust included student midwives we did not include these figures in this report as they should be supernumerary.

The service had moderate turnover rates. Records showed the turnover rate for July 2022 was 18.1%. Leaders were working with human resources to retain staff. However, staff told us that because the unit was busy, they rarely had time to attend wellbeing sessions.

The service had reducing sickness rates. Managers monitored sickness rates and the reasons for long term sickness. Records showed the annual sickness rate for the services was 9%. The figure varied in each department and included 6.7% of staff who were on long term sick.

Managers used bank staff to backfill shifts but limited the use of agency midwives and requested staff familiar with the service. Records showed during July 2022, the service used a total of bank use was 74% and 3% of hours of agency staff, whilst 22% of requested bank hours remained unfilled. This confirmed the unit was understaffed.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers used familiar bank staff who were employed by the service. Managers told us agency staff were orientated to the service on arrival.

Managers supported staff to develop through yearly, constructive appraisals of their work some of the time. Appraisal data was sent weekly to managers and included the names of those staff whose appraisal was due to expire in the next three months. However, records for August 2022 showed 49% of staff had not received their annual appraisal. Leaders cited operational challenges and errors when uploading appraisals to central systems as two key issues.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. The professional midwifery advocate role was not embedded throughout the trust. This was because leadership support was limited with no dedicated time the lead role had not been defined and posts were vacant.

Staff did not have reasonable opportunity to discuss training needs with their line manager and were not supported to develop their skills and knowledge. This was because appraisal rates were low and so were staffing levels most of the time. This had a negative effect on staff wellbeing.

Managers escalated staffing concerns in line with the services escalation procedure. Staff were often moved from one area to another, night shifts were often understaffed and the busy triage area, was short staffed most of the time. During our inspection we noted that staffing had a negative impact on capacity, by lunchtime triage was full and staff lacked the time to perform their duties safely.

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.

The service had enough medical staff to keep women and babies safe. Leaders had split the obstetrics and gynaecology rotas which meant that on call doctors only covered one specialism. This change had been welcomed by all staff.

The service employed 28 consultants who covered 18 whole time posts and 16 of these contributed to the obstetric on call rota, which was separated into obstetrics and gynaecology. This meant that consultants were on call 1:9 days. Safer childbirth guidance (2007) recommended a consultant presence of 168 hours per week on the delivery suite, for a unit of this size with 5,000 births per year. However, the service was working in line with the Royal college of obstetrics and gynaecology workforce report 2017 and provided 98 hours of consultant presence per week between 8am and 10pm. The risk of no consultant presence overnight was mitigated through consultants providing on call cover, at night, with a journey time of 30 minutes to site.

The service employed a total of 65 medical staff which included speciality 23 registrars and 11 trust grade registrars.

The medical staff matched the planned number. Reports showed in July 2022 actual medical staffing numbers matched planned staffing numbers. However, during the inspection we found that on the 17th of August 2022 medical staff on the night shift had to see 26 women waiting in triage because there were not enough day shift staff to assess staff within national time frames.

The service had low vacancy rates for medical staff. The service was recruiting two full time locum consultants to cover the work of a consultant who was completing academic work and long term sickness.

Maternity

The service had low turnover rates for medical staff. Recent data from the trust showed the turnover rate for doctors was 0.4%. However, doctors training on a divisional rotation roster were due to change in early October 2022. Some of these staff told us they would not remain at the hospital because of the high acuity of patients and the fast pace of work, which included administrative tasks they had to complete in their own time due to work pressure and lack of administrative support.

Sickness rates for medical staff were low and reducing. Records showed monthly sickness rates for medical staff up to May 2022 were 4.2% this included 2.21% who were sick for over 28 days.

The service had low and/or reducing rates of bank and locum staff. The use of bank and agency staff was authorised by leaders and monitored by managers. Records showed during July 2022. Figures showed in July 2022 54% of doctor hours were filled by bank staff and 2% was filled by agency. Records also showed 44% of shifts remained unfilled.

The service could access locums when they needed additional medical staff most of the time. Leaders told us that maternity medical staffing across London had been a challenge due to competition over the rates of pay for locums. The service had recently reviewed the pay rates to encourage locums to work at the service.

The service made sure locums had a full induction to the service before they started work. Consultants and medical managers were responsible for making sure locums received a full induction prior to working for the service. Agency and Locum staff received a condensed Induction procedure before commencing work and advised staff that it was their responsibility to comply with trust policy for induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Leaders had recently split the obstetrics and gynaecology on call rota to make sure that there was adequate cover in both areas to improve the speed of patient reviews and flow across the unit. Doctor staffing was reviewed at the staffing huddle and fed into the trusts four hourly acuity reviews.

The service always had a consultant on call during evenings and weekends. Consultants worked on site until 10 pm most days and records showed average consultant cover on labour ward happened 98% of the time.

Managers supported doctors to develop through constructive clinical supervision of their work most of the time. Doctors told us that clinical supervision was hit and miss across the unit. Whilst doctors working on triage told us they felt they were well supported by their seniors. Junior doctors felt there was limited time to have constructive conversations about their work. Junior doctors described frustration at not getting the right amount of study leave to attend all the relevant training sessions.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily most of the time. Ante and postnatal staff recorded care in mothers handheld notes and proformas via the internal electronic patient record. But unlike their sister location, staff recorded care in labour on paper care records. This meant that records were difficult to maintain and audit. The inspection team reviewed six sets of notes during the inspection, we found that staff recorded care contemporaneously in the paper records, however, audit was difficult and because medical records were not filed consistently.

When women transferred to a new team, there was a potential for delays in staff accessing their records. This was because there was a combination of paper and electronic care records and staff used a different approach to documentation at the trusts other locations. Community midwives completed handwritten records assessments and then input the data onto the digital patient record. We were told this was because there was not enough digital hardware to support the workforce with recoding care electronically.

Records were not always stored securely. During the inspection we observed computers and handwritten notes being left open in clinical areas. This meant data was not secure.

However, leaders had recognised that the care record was a risk and recorded this on the internal risk register.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely most of the time. The safe storage of medications had been on the risk register since 2018, because some clinical rooms did not have locks and other clinical rooms were accessible by key code access and not swipe card access and some fridges were not lockable.

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

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

Staff completed medicines records accurately and kept them up-to-date. Staff had access to electronic prescribing at the trust. However, we found examples of medication prescribed on paper medication charts which staff reviewed during care.

Staff stored and managed all medicines and prescribing documents safely most of the time. Controlled medication was stored in locked units and shift co-ordinators managed the keys. Staff completed daily checks of the stock in line with national guidance. However, records we checked on labour ward demonstrated that documentation was not always completed in line with trust policy although the stock count was accurate.

Staff completed daily checks of medicines and equipment required in an emergency which were stored in emergency resuscitation trolleys. However, we saw that the emergency medicines were not stored in tamper proof boxes or drawers. This does not follow resuscitation council guidance. Although it is recognised that medicines required in an emergency should be accessed immediately it is also recognised that emergency medicines must be stored in tamper proof boxes or drawers.

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

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

There was lack of pharmacy support at the hospital and this was recorded on the internal risk register in 2018. This was because there was only part time cover for maternity services.

Incidents

The service managed safety incidents well most of the time. Staff recognised and reported incidents and near misses. Managers did not always complete thorough investigations. Managers shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

Staff reported staffing incidents in line with the National Institute of Health Care and Excellence (NICE 2015) guideline 'Safe midwifery staffing for maternity settings'. Records showed Staff reported 135 staffing incidents at Royal London from February 2022 to August 2022. Managers reviewed the reports and two of the incidents were rated as potential low harm, because patient care may have been slightly compromised. However, the data identified numerous occasions when lack of staffing affected care, for example in July 12 women had their inductions of labour delayed.

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

Staff reported serious incidents clearly and in line with trust policy. Leaders used an online perinatal mortality tool to report serious incidents trust wide. Leaders monitored stillbirths, fetal loss, neonatal and post-neonatal deaths and produced a biannual Perinatal Mortality Reviews Summary Report (PMRT). The most recent Perinatal Mortality Reviews Summary Report from January 2022 to August 2022 recorded 63 stillbirths and 26 neonatal and post-natal deaths. The review panel concluded that only two of these cases had care issues that may have made a difference to the outcome for the baby.

Leaders reviewed care of women and babies trust wide and records showed the review process identified care issues in a total of seven cases. The PMRT report showed out of the seven cases there were no 'planned actions' recorded for three cases or time frames for closure of the incidents. Those incidents that did include recorded 'actions planned' did not display clear time frames for completion of those actions.

Records showed since January 2022 the service had 26 outstanding incidents over 60 days. These included five serious incidents two of which had been delayed due to investigations from the Health Service Investigation Branch (HSIB). The hospital referred six cases to HSIB in the last six months.

The hospital reported one never event in September 2021 for a retained swab and the trust wide there was a total of three retained swab never events.

Maternity

Managers shared learning about never events with their staff and across the trust. Records showed the hospital had stopped safety messaging during Covid-19. However, due to a poor outcome the safety briefing was reinstated.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong most of the time. Inaccurate grading of serious incidents meant that some people did not receive the appropriate feedback or apology in line with Duty of Candour legislation.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning and actions were shared with the staff via interactive boards, emails and on staff message groups. Leaders disseminated quarterly messages amongst staff which included learning from incidents. Also, managers produced a divisional newsletter. Records showed learning was shared within this publication monthly.

Staff met to discuss the feedback and look at improvements to patient care. Leaders met quarterly to discuss improvements and update actions plans and records confirmed this. Themes were shared with staff and included but not limited to workload issues, verbal, general poor communication, staff shortages and perineal trauma.

Managers investigated incidents thoroughly most of the time. Women and their families were involved in these investigations. Leaders at trust level met weekly for a one hour slot to review and rate incidents. However, there was limited evidence that changes had been made because of feedback in all cases. Several staff raised concerns about how incidents were reviewed and categorised, because they felt the organisation had normalised poor outcomes. Records confirmed this we saw several examples where leaders had not considered all aspects of care or rated the incident in line with the national serious incident investigation framework.

For example, we saw evidence where a woman had to be readmitted following her initial discharge for further treatment this was graded as no harm. This meant the level of harm did not trigger a duty of candour apology. This is not in line with the serious incident framework definition of moderate harm. Downgrading important incidents meant that patients were not followed up and that staff were not given opportunities to learn.

Managers debriefed and supported staff after any serious incident. Managers told us that there was a process for debriefing staff after serious incidents. However, staff told us that this was unpredictable dependent on the consultant or matron on duty and the capacity of the unit.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced most of the time. They supported staff to develop their skills and take on more senior roles some of the time. Staff told us they were not always visible or approachable in the service for patients and staff.

Maternity

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

Women and newborn services at Royal London Hospital had gone through a process of change in the last year. Senior staff had left the hospital which had created a period of instability. The service was overseen by a local leadership team that included a divisional director, associate director of midwifery and director of operations. The hospital was in the process of recruiting an associate director of midwifery.

The changes to midwifery leadership in the last 12 months created a delay in the review of services. Although leaders felt this was an opportunity to refresh the maternity strategy and create a positive culture of improvement.

Maternity leaders reported quarterly to the Royal London Hospital maternity and neonatal board which reported to the Bartshealth Group strategic maternity and neonatal board. The director of nursing's was the maternity executive safety champion. The leadership team was supported by the hospitals safety champion, the chair of the maternity voices partnership, the non-executive director safety champion, and the care group chief nurse maternity champion.

The non-executive director (NED) worked alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry. The NED worked with, the chief nurse and director of midwifery to monitor services, review and take actions of any identified concerns.

The general manager reported into the director of operations women's division and the obstetric clinical lead reported to the clinical director of obstetrics and gynaecology"

The consultant governance lead, the consultant for labour ward and fetal medicine, the consultant for education and the consultant for fetal monitoring reported to the obstetric clinical lead.

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

Vision and Strategy

The services implemented a new strategy. The current vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them, but monitoring was not always effective.

Leaders had implemented a new strategy that incorporated, local demand, capacity, and national expectations. For example, the completion of the Ockenden recommendations (2022) immediate and essential actions, by working with the local maternity and neonatal system (LMNS) and the local integrated care board (ICB). The new strategy included key principles, maternity was one of five programmes of work that the acute provider collaborative (APC) was leading on, on behalf of the Northeast London integrated care board. The LMNS would become the APC Clinical Board for maternity and Neonates to reduce duplication. The membership, scope, and objectives of the LMNS would be reviewed to help it be as effective as possible in the current context and looking ahead.

Maternity

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

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

However, leaders lacked time to monitor the current strategy. During the inspection we saw numerous examples of missed opportunities to strengthen the strategy.

Culture

Not all 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.

Staff had raised concerns about the negative attitudes and abuse from patients or carers. Records showed staff reported 28 incidents of verbal abuse, intimidation and anti-social behaviour aimed at staff during the reporting period August 2021 to July 2022. The impact of abuse from the public is that staff feel disempowered and anxious when they come to work.

The non-executive director completed a maternity safety visit to the hospital in July and spoke to staff. Staff fedback their concerns about workforce pressure, the digital IT infrastructure and capacity for planned work. Staff were able to celebrate local success on quality improvement such as the planned implementation of triage and work to improve culture.

Staff survey results were not always positive. For example, the proportion of midwives who would recommend their trust as a place to work ranged from 47-51% this is lower than the national average of 64%. This echoed the voices of staff we interviewed.

The response of junior doctors who described their clinical supervision as good or very good was between 84-90%. However, several doctors told us they felt burnt out and had to complete training in their own time which had a negative impact on their wellbeing.

Managers did not always utilise wellbeing resources and support for staff well-being effectively due to difficulty in securing backfill to allow staff to leave clinical areas. The impact of this is staff feel disengaged with the service.

Managers were described as remote and were not visible by teams, particularly in acting on and giving feedback to staff on concerns raised.

Staff raised concerns about increasing levels of aggression from the population served and the effect this had on morale in the team.

Maternity

Women, relatives, and carers knew how to complain or raise concerns. The hospitals divisional safety champion worked with the patient experience midwife to improve care and communication. Women knew how to complain, this was because the service clearly displayed information about how to raise a concern in patient areas.

Staff expressed concerns about women's experience. A common theme of complaints was poor communication and staff rudeness in all the services, highlighting the need to support both staff and women's experiences. The patient experience midwife had become an integral part of maternity services and worked closely with the hospitals safety champion to improve communication with mothers, pregnant people, and their families.

The service did not clearly display information about how to raise a concern in all areas of maternity. We did not see this information displayed in all areas for example the triage area and labour ward.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Records showed since May 2022 the service had received 18 complaints. Themes included poor care and treatment and lack of communication; these themes are echoed in the CQC maternity survey.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Records showed the service acknowledged complaints and gave people feedback which included any learning points for staff involved in care.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared feedback with those staff involved in the complaints, however we saw no evidence of complaints themes being included in the divisional newsletter.

Governance

Leaders did not operate effective governance processes in all areas, throughout the service and with partner organisations. Not all staff were clear about their roles and accountabilities and or had regular opportunities to meet, discuss and learn from the performance of the service.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance when leaders provided it. Staff accessed policies on-line whenever they needed them. However, clinical guidelines did not always consider all aspects of care. We reviewed the clinical guideline for the management of late preterm infants on transitional care and the introduction of the 'each baby counts learn and support escalation tool kit'. But we saw no evidence of staff using a newborn RAG rated assessment tool at birth to consistently identify babies at risk of deterioration. The implementation of this tool would help improve re-admission rates, increase support for infant feeding and improve health outcomes for newborn babies.

Also, we found there was no current standard operating procedure for telephone triage or triage. We raised this with managers who advised us that these would be implemented with the triage system, however, there was no agreed time for the implementation.

A hospital site specific maternity and neonatal board met every month and was accountable to the hospital executive board and reported progress to the Bartshealth Group strategic maternity and neonatal Board. The team aimed to

provide a single hospital level governance forum to provide assurance on performance and risk. The group had a standing agenda, which included a review of the Clinical Negligence Scheme for Trusts (CNST) action plan, the maternity dashboard and group updates. Board membership included the director of nursing, the hospital medical director, the associate director for midwifery and the divisional operations lead.

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

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

Leaders attended monthly divisional quality, safety, and governance meetings. The meetings had a formal agenda and minutes were produced and available to staff throughout the service. The team reviewed serious incident referrals that qualified for a Health Safety Investigation Branch (HSIB) investigation. The process was designed to strengthen governance processes throughout the service and provide assurance to the board that improvement had been made.

Recently appointed leaders recognised the need to strengthen processes to conform to national policies. Records showed the group director of midwifery submitted reports to the board quarterly via the chief nursing officer. The reports showed there was oversight on several work streams, this included strengthening the maternity dashboard data, finalising local pathways, and standardising documentation. However, we saw the pace was slow.

Over the last two years systems had been implemented to improve local resilience to service demands. Although, some of these were ineffective because recruitment and retention remained a barrier to progress throughout the service.

Furthermore, leaders did not monitor all aspects of care. We saw examples of poor practice. For example, staff had not safely stored fetal remains in line with the Human Tissue act (2004). There was no designated area to store fetal remains away from other tissue. Remains were stored in an unlocked room in an unlocked fridge and leaders had not monitored this effectively. We raised our concerns with leaders, who took immediate action to install a lock on the fridge and request a key coded lock.

Also, incidents were not appropriately categorised in all cases, which meant that duty of candour was not implemented and there were missed opportunities to make improvements.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff accessed policies on-line whenever they needed them. However, we found there was no current standard operating procedure for telephone triage or triage. We raised this with managers who advised us that these would be implemented as part of the triage system, however, there was no agreed date for implementation.

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.

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

Maternity

The service participated in relevant national clinical audits. The hospital submitted data to MBRACE Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the Uk audits and Perinatal Mortality Review Tool (PMRT) clinical audits.

Outcomes for women were not always positive, consistent, or met expectations, such as national standards. The percentage of babies born 'Small-for-gestational-age' was 8.1% for the trust overall and the percentage of preterm births 6.9% overall were higher than expected. The hospital managed care for a very diverse high risk population. Which meant there were many factors that influenced outcomes for example, social deprivation, ethnicity, or care issues.

Leaders monitored the outcomes of the saving babies lives care bundle the next audit was due to be published in December 2022.

Managers and staff used the results to improve women's outcomes. Managers input data onto a maternity scorecard so that it was easy to review and benchmark. Improvement is checked and monitored. The scorecard was reviewed on a regular basis and leaders produced reports and fed information to the trust board.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Leaders arranged 26 audits for 2022. Specialist midwives completed audits for their area. For example, the fetal monitoring midwife completed fresh cardiotocograph (CTG) classification and fresh eyes audits and a reduced fetal movements and antenatal CTG Analysis.

However, there was lack of audits on the birth centre. For example, there were no obstetric anal sphincter injury (OASI) audits to monitor the severity of perineal trauma. The long term consequences of high level trauma lead to long term poor women's health.

Managers shared and made sure staff understood information from the audits. Managers shared audit outcomes with staff via emails, handovers, posters, and the directorate newsletter. Also, audit outcomes informed training.

The service was accredited by the clinical negligence scheme for trusts. However, recent audits showed they had not met all 10 safety standards.

Maternity safety champions met trust wide on a regular basis from all areas of maternity. The team reviewed the perinatal quality surveillance tool, maternity dashboard, continuity of carer, progress on the clinical negligence scheme for trusts (CNST), neonatal care and discussion on the maternity safety board. The impact of larger meetings is that one hospitals challenges may impact on oversight of the other hospitals performance. For example, we noted that records often focused on Newham hospital. However, evidence provided by the trust confirmed that local risk and regulations meetings were held monthly.

Leaders implemented NHS London's 'Operational pressures escalation levels maternity framework' and escalation policy for London. This policy ensured a standardised approach to communicating changes in trusts operational capacity to improve consistency, reduce variation in practice across the region and improve coordination between London maternity services and the local ambulance service.

The hospital risk register recorded 22 current risks to services and people. Three risks were graded as catastrophic one of these was the lone working risk to community midwives. The mitigation was for community midwives to record their locations and use taxi services out of hours. However, there was no evidence of midwives being offered personal protection devices.

The other catastrophic risk was lack of locks of medication cupboards this had been listed in 2018 and yet there was no closure date of this risk. Two risks had been graded as major; one was the lack of capacity on the labour ward to manage inductions of labour, the other was lack of compliance to fetal monitoring training due to staffing.

Risk was not always managed well by the hospital. The trust had failed to list midwifery staffing as a risk despite records clearly confirming this. Leaders had been slow to resolve risks and lost oversight of the risk register. For example, the lack of locks being recorded on the internal risk register since 2018, yet the was no mitigation to limit the risks to staff and patients.

Also, leaders failed to effectively monitor the working practices at the Barkantine birth centre. For example, the lack of information recorded in risk assessments at women's 36 week appointment, which is meant to determine a risk category for mothers so that women at risk of poor outcomes are given the correct advice and opportunity to deliver their babies in a tertiary hospital. Records showed earlier this year a very small baby was born in poor condition at the stand-alone birth centre. The investigation did not include a review of antenatal care or comment on the 36 week assessment. Leaders did not refer to the low birth rate or query why the mother was advised she could give birth there. This suggests serious missed opportunities to improve care and complete lack of oversight by the leadership team to always ensure safe care.

Information Management

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

The trust used a combination of electronic and paper-based records systems. Staff reported poor documentation as an incident. We found the electronic patients record systems did not always support staff to maintain a contemporaneous care record because of connectivity or system glitches. It relied on a pressured workforce to enter data and print records in retrospect especially within the community setting. This was identified as a significant risk to the service on the internal risk register and was due to be reviewed at the end of September 2022.

The data quality failed for four of the twelve measures in the NHS Digital maternity dashboard. Data quality in relation to the maternity services dataset had been an issue at the trust over the past few months.

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

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

The digital midwife provided technological support for staff using the IT systems. They monitored the maternity dashboard and provided data to leaders. The trust was in the process of creating a new digital strategy.

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.

Leaders implemented a helpline to support triage. Women and birthing people could call the helpline with any concern throughout the week and weekend. The helpline was staffed by experienced midwives who followed scripts and guidelines to provide help and support. We spoke with leaders and staff who were unable to articulate if an audit had been completed for the telephone triage helpline. However, during the factual accuracy process the service provided evidence of audits of its telephone triage service which was presented at the July 2022 Women's service audit meeting.

Patient advice leaflets for induction of labour and caesarean section were not visible on the antenatal ward and there were no clear posters in different languages to access information in other languages were visible.

There were several ways for women, birthing people, and families to give feedback, although they are not always well publicised, and there are fewer options for those who don't speak English well.

The local Maternity voices partnership (MVPs) was well funded, with strong links and support through Best Beginnings.

Women, birthing people, and families could feedback via the trusts Friends and Family survey, and complaints although it was not obvious in most areas or on the website how to do this.

Managers told us there were plans to implement cultural competency training which will be critical in a service caring for such a diverse population.

The health safety investigation bureau (HSIB) raised concerns antenatal care pathways for women who failed to attend their appointments, because the trust had not explored the barriers that made it difficult for these women to access services.

The Maternity Mates project and 'BAME' women's pregnancy support network were great examples of collaborative working with the community but not always well signposted.

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.

Royal London hospital committed to improve learning, improvement, and innovation via the maternity strategy.

Leaders implemented a quality improvement project for managing sickness to facilitate return to work for staff. Senior midwifery staff supported delivery of frontline care, resulting in nil adverse clinical events being reported as a result of staffing gaps.

The service had implemented a Midwifery telephone advice line and the number was displayed on women and pregnant peoples care records. Midwives manned this service around the clock to make sure women could seek advice and support without having to attend hospital. Leaders were monitoring the outcomes of this new service.

The service had introduced an interpreter on wheels service, this was a digital tablet on wheels that had links to local interpreting services via video calls. Although, at the point of writing the tablets had not been installed in triage.

Maternity

Outstanding practice

We found the following outstanding practice:

- Safeguarding and Perinatal mental health services had been tailored to meet the needs of the local diverse population. The team worked collaboratively to develop care pathways with third party organisations for the benefit of vulnerable women who accessed the service. Outcomes were monitored by the trust and the local authority. This meant that staff caring for women after birth could access an enhanced health visiting service for vulnerable women. This multi professional approach to planning care for women with complex mental health and social needs was integral to the long term emotional wellbeing of new parents.
- The service had recently introduced a midwifery advice line so that women could contact the service at any time to seek advice and support. The telephone lines were manned around the clock and managers monitored the effectiveness of this service.

Areas for improvement

MUSTS

The Royal London Hospital – Maternity

- The service must ensure that staffing in triage is effectively monitored, and that clinical staff are supported with the clerical tasks to support the recording of arrival times and patient demographics when women and pregnant people arrive for care. (Regulation 12(1)(2)(b))
- The service must ensure that there is a 'round the clock' supernumerary shift coordinator on labour ward. (Regulation 12 (1)(2)(b))
- The service must ensure that pharmacy provision is increased, and that all medication is stored safely so that it is tamper proof. (Regulation 12(1)(2)(g)
- The trust must implement an appropriate triage system and it is monitored within set times frames. (Regulation 12(1)(2)(a)(b))
- The trust must ensure that Gap Grow practice reflects national guidance all the time (Regulation 12 (1)(2) (a)(b)
- Leaders must ensure that it improves its digital care records systems to make sure that patient records are completed contemporaneously, and data is accessible across the trust and stored safely. Regulation 17(1)(2) (c)
- The service must ensure that patient records are stored securely and monitor staff compliance to this. in line with the general data protection act. (Regulation 17(1)(c))
- The service must ensure that that there is a clear guideline for storing and handling fetal remains and monitor its effectiveness. (Regulation 17(1)(b))
- The service must ensure that it completes thorough reviews of serious incidents to ensure that all incidents are categorised in line with national guidance to improve long term outcomes for mothers and babies. (Regulation 17(1)(2)(a)(b))
- The trust should ensure that there are enough suitably qualified competent staff to meet the needs of the service. (Regulation 18(1)(2)(a)(b))

Maternity

- The service must ensure that they complete a risk assessment about the lack of resuscitaires in each room to mitigate the risk of delays in emergency care. (Regulation 17 (1)(2)(a)(b))
- The service must ensure that staff receive their annual appraisal within trust targets and that staff are given time to complete their mandatory training to improve staff morale. (Regulation 17(1)(2))

Shoulds

- The trust should ensure that clinical staff receive clerical support to ease the non-clinical burden.
- The service should ensure that it completes thorough reviews of all serious incidents to ensure that all incidents are categorised in line with national guidance to improve long term outcomes for mothers and babies.
- The service should ensure that they make the implementation of centralised cardiotocograph (CTG) monitoring a priority in line with national guidance.
- The service should ensure that it implements RAG rated newborn risk assessments completed at birth to identify those babies most at risk and ensure that staff provide the correct level of care to reduce admissions to the neonatal unit.
- The service should ensure that clinical staff complete all aspects of the SBAR tool.
- The service should ensure that triage wait times are monitored effectively.
- Should consider introducing human factors training is included in the multi-professional skills and drills training in line with the Ockenden immediate and essential actions.
- The service should consider allocating antenatal staff longer appointment times to make sure that women are risk assessed at each appointment and staff have time to record this.
- Leaders should ensure that all staff receive their annual appraisal on time.

Our inspection team

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

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

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

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

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

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