Homerton University Hospital NHS Foundation Trust

Homerton University Hospital

Quality Report

Homerton Row
Hackney
London
E9 6SR
Tel: 020 8510 5555
Website: http://www.homerton.nhs.uk/
Twitter: @NHSHomerton

Date of inspection visit: 28 October and 4 November 2015
Date of publication: 11/02/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Maternity and gynaecology	**Requires improvement**

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Requires improvement 	We inspected the trust's maternity services only. We found improvements had been made to ensure the safety of the service and action had been taken to ensure the appropriate care and welfare of women. However we found robust observational checks of babies were not in place. The cleanliness and hygiene of the unit had improved significantly. The areas we inspected were visibly clean and there was a system of checking processes for ensuring high standards of cleanliness were adhered to. However we found a few isolated incidents where cleanliness could be improved. There was sufficient evidence that the warning notices for care and welfare of women and their babies and cleanliness and infection control had been met. We found improvements had been made in assessing and monitoring the quality of the service. There were strengthened governance systems in operation and there was staff engagement in improving the quality of the service. However we found there was still a need to improve and strengthen governance structures and reporting systems. Governance information was reported adequately at appropriate meetings, however external challenge by the trust's centralised governance team needed to be further embedded and supported by staff in the maternity unit to ensure appropriate support and challenge. A leadership programme was planned for senior staff within the service. There was evidence the warning notice had been met, however the governance structures in place needed further review and embedding to ensure they were consistently protecting women and their babies from unsafe care. We issued a requirement notice.

Homerton University Hospital

Detailed findings

We looked at maternity services only

Detailed findings

Contents

Background to Homerton University Hospital

The hospital provides maternity services for a diverse local community of around 252,000 women predominantly from the London Borough of Hackney. The area has amongst the highest fertility rates in London. The 2015 deprivation indices showed that Hackney was the fifth most deprived local authority in the country.

The service delivered over 5,842 babies in 2014. From 1 January 2015 to 30 September 2015 (nine months) 4,464 babies were delivered by the service.

There is a consultant led delivery suite and a midwifery led birth centre. The maternity unit is supported by a level three neonatal unit. The hospital provides one of the largest Neonatal Intensive Care Unit (NICU) services in London. It provides medical intensive care and supports the local population of preterm and sick term babies of Hackney. The unit works within the context of the North Central and North East London neonatal operational delivery network for neonatal care. This network has a total of 13 units which deliver different levels of care. The hospital is a regional NICU and provides complex medical care for infants from 23 weeks of gestation.

Findings from our previous inspection in March 2015

We rated the service as 'Requires Improvement' following our inspection in March 2015. The maternity unit reported a high number of serious incidents including two maternal deaths in 2013, two in 2014 and a further one in January 2015. The service was not consistently learning from adverse incidents and implementing the necessary improvements. Women and their babies were not always being adequately monitored. The environment and equipment were not appropriately cleaned and equipment was not consistently maintained or checked.

All staff groups gave positive feedback about the leadership and culture of the service. However the service did not have a vision or a strategy. Governance processes were not fully embedded in practice. The risk register did not include all significant risks.

We found issues identified at our first unannounced visit on 17 March 2015, such as the environment, which the trust stated they had taken action to address, had not been resolved when we returned one week later for an announced inspection.

The purpose of this inspection

On 31 March 2015, using our enforcement powers we served three warning notices in response to concerns with escalation processes for the care and welfare of women and their babies; assessing and monitoring the quality of the service; and cleanliness and Infection control.

We told the trust to be compliant with the three fundamental standards by August 2015. The trust and City and Hackney Clinical Commissioning Group (CCG), with support from other stakeholders developed a combined action plan to address our inspection findings and areas for improvement for the service.

The focus of this inspection was to review the trust's progress against each of the three warning notices. We did not conduct an in depth review of evidence against each of our five key questions and key lines of enquiry. Our inspection was unannounced over two days.

Detailed findings

Our inspection team

The inspection was carried out by the head of hospital Inspection for North London, inspection manager and inspectors for North East and Central London, a midwife, a head of midwifery and a consultant obstetrician. Our inspection was unannounced on 28 October and 4 November 2015.

Maternity and gynaecology

Safe	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

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Summary of findings

We found improvements had been made to ensure the safety of the service and action had been taken to ensure the appropriate care and welfare of women. However we found robust observational checks of babies were not in place. The cleanliness and hygiene of the unit had improved significantly. The areas were visibly clean and there was a system of checking processes for ensuring high standards of cleanliness were adhered to. However we found a few isolated incidents where cleanliness could be improved. There was sufficient evidence that the warning notices for care and welfare of women and their babies and cleanliness and Infection control had been met.

We found improvements had been made in assessing and monitoring the quality of the service. There were strengthened governance systems in operation and there was good staff engagement in improving the quality of the service. However we found there was still a need to improve and strengthen governance structures and reporting systems. Governance information was reported adequately at appropriate meetings, however external challenge by the trust's centralised governance team needed to be further embedded and supported by staff in the maternity unit to ensure appropriate support and challenge. A leadership programme was planned for senior staff within the service. There was evidence the warning notice had been met, however the governance structures in place needed further review and embedding to ensure they were consistently protecting women and their babies from unsafe care. We issued a requirement notice.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Summary

The service had addressed the requirements of the warning notices for care and welfare of women and cleanliness, infection control and hygiene. The overall standard of recording women's observations data had improved. Early warning scores were recorded electronically and calculated automatically. A new escalation protocol was in place, with training for all staff in the unit to identify deteriorating patients. All of the hospital and community staff we spoke with were able to articulate the actions that had been taken following the five maternal deaths and our previous inspection.

Cleanliness and infection control processes were significantly improved, with effective checking and audit processes to ensure standards were being maintained. Areas we visited were visibly clean. We found a few isolated incidents where cleanliness could be improved.

We found several areas of improvement were needed to ensure safety, including the robust recording of observations of babies, implementing recommendations from serious incidents and incidents, secure storage of medicines and the recording of equipment and environment checks.

Incidents

- At our last inspection in March 2015 we had significant concerns that systems and processes for incident reporting and investigation were not sufficiently safe. Following our previous inspection, the trust and external stakeholders including their commissioning bodies and NHS England, undertook an extensive review of the systems and processes for reporting and investigating incidents. The systems had been strengthened by structured governance, clearer roles and responsibilities and increased support from stakeholders. All moderate and serious incidents and deaths of women continued to be reported to the Chief Nurse and Director of Governance and other senior managers in the trust.
- Since our last inspection there were a further five serious incidents (SIs) reported in the maternity service, and a total of fifteen serious incidents were reported in 2015 at the time of our inspection. This was fewer than the 29 SIs reported in 2014. NHS England updated the SI reporting framework in April 2015, changing some criteria and extending timescales for completion of investigation reports from 45 to 60 days.
- In June 2015, there was one anaesthetic Never Event in theatres involving a woman having a caesarean. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented. Senior staff were aware of the investigation and had reviewed if there was any learning for the maternity service.
- Newly appointed midwives told us the service was candid about the findings of the March 2015 inspection report and their interviews and induction included a detailed description of the impact and learning from serious incidents and maternal deaths that had occurred.
- Doctors in training reported that they knew how to report concerns and that SI learning was shared at the end of handover.
- Midwives not in senior positions were unable to articulate learning from more recent incidents. They were able to freely explain the outcomes of the previous report but when asked if there had been any serious incidents since the last inspection they were unable to identify any, even though reports of investigations had been completed and learning shared at meetings and in newsletters.
- Debriefing sessions continued to be held with staff following SI investigations.
- Some actions from the maternal death investigations needed embedding. At our last inspection we identified use of interpreting services was not systematically applied. A serious incident was reported in December 2014, where an advised medical termination was stopped after further clinical review. A key contributing factor was the failure to request support from an interpreter. The trust's access to interpreting services policy was revised and an audit completed in July 2015 to ascertain whether women who are not fluent in

English have access to adequate professional advocacy support in the antenatal, intrapartum and postnatal periods. The audit found improvements in staff making use of this service. Translation services were accessible 24 hours a day and face to face interpreters were available on weekdays. In September 2015, the trust had reminded staff in the fortnightly newsletter about accessing advocacy and translation services. However, in July 2015, an SI was reported which involved unexpected or unplanned prolonged admission to Intensive Care Unit (ICU) involving the failure to involved an interpreter. The investigation was in progress at the time of the inspection. Subsequently the trust told us that access to or use of advocacy or translation has not been found to be involved in this case.

- Changes had been made to the swab count procedure following the retained vaginal swab never event in January 2015. Staff involved had discussed the incident, the maternity guideline for swab counts had been updated, verbal briefings with staff were undertaken and the first bi-monthly swab audit was completed and presented in September 2015.
- Midwives and doctors confirmed that learning from incident investigations continued as an agenda item in Friday morning obstetric meetings, weekly perinatal morbidity meetings and the monthly perinatal mortality meeting. Attendance lists we reviewed showed midwives and midwifery assistants attended most frequently than consultant or middle grade doctors at the monthly multi-disciplinary meetings.
- The action plans from Never Events and maternal deaths were a standard item on the patient safety committee agenda and were scrutinised closely each month. Clinical and managerial staff were held accountable for the completion and monitoring of action plans by the executive team.
- In the quarterly maternity governance meetings of the Surgery, Women's and Sexual Health Services directorate, areas of concern identified during the last inspection regarding incident reporting and investigation were escalated and actioned through the maternity risk register. Descriptions, including immediate actions following newly reported serious incidents and lessons embedded following completed investigations were provided. There were over 30 recommendations from root cause analysis investigations that were in progress, and these were monitored by a multidisciplinary working group and in monthly maternity risk management review meetings.
- While some progress for timely review of incidents had been made, the 45 day timescale was not being met in approximately 20% of cases. Reminders were sent to investigating managers to review and close open incidents on a monthly basis. At the time of our inspection over 400 incidents, reported September 2014, had yet to be closed. The incidents were categorised and the level of harm was known. This issue was on the maternity risk register and was being managed through the maternity risk management review meetings with escalation to the trust's patient safety committee. The trust told us delays in the completion of investigations within the set timescales may be caused by factors outside the Trust's control. For example, the delays to the completion of the five SI s that took place in maternity between 1st April and 31st December 2015 were each caused by external review/ panel members.
- The reporting rate of incidents continued to be better than the national average, and the service remained in the top 25% of reporting hospitals.
- Weekly perinatal morbidity meetings were well attended, and relevant cases, including reported incidents were discussed.

Maternal deaths

- At our last inspection the trust told us there had been five maternal deaths between January 2012 and March 2015. No further maternal deaths were reported following our inspection in March 2015 to date.
- Actions to address root causes or contributing factors of maternal deaths were evidenced in a number of areas. There was evidence that the observations of deteriorating women had improved. An electronic tool to measure Maternity Early Obstetric Warning Score (MEOWS) observations was routinely used, and staff demonstrated this tool confidently. MEOWS audits were completed and results demonstrated over 90% compliance in recent months. These were fed back

weekly on wards areas and fortnightly in the community. This was complemented by training and consistent use of the obstetrical triage acuity scale, which was also audited.

- Action plans following the investigations into the maternal deaths were monitored monthly by the trust's patient safety committee, with senior representatives from the maternity team providing evidence that actions had been completed. At the last inspection evidence provided showed that not all actions had been completed. At this inspection senior managers told us that these actions had all since been implemented. All actions relating to the two maternal deaths in 2013 were confirmed as closed by the Commissioning Support Unit and shown on STEIS as closed on 8th December 2015.
- Three staff members told us the trust was open about the causes and learning of the maternal deaths when they were interviewed for their posts.
- Two support workers were able to describe learning from neonatal deaths.

Duty of Candour

- We found that processes for duty of candour were being strengthened. A patient incident liaison officer was responsible for managing duty of candour processes for the whole trust and provided centralised support and advice.

Cleanliness, infection control and hygiene

- We found that the maternity service had addressed the warning notice for cleanliness, infection control and hygiene that we served following our previous inspection. The standard of cleanliness across the service, from wards to theatres, had improved significantly. Clinical areas were dust free and visibly clean. The use of 'I am clean stickers' was evident, but we found that some were not dated and/or signed.
- We were told by all staff groups that there was immediate feedback about our findings in this area. An action plan was shared with all staff in the maternity service and it was discussed at handover and in all-staff emails.
- Cleaning teams were visible on the wards at the time of the inspection.
- The staff we spoke with were aware of the infection control lead for the trust.
- The trust had introduced daily checklists for hygiene and equipment in each room within the maternity service. Midwives were responsible for completing the checklists at the start of each shift. Checklists from the day prior to our inspection were not available and of those we saw on the day, for 28 October 2015 there had not been time for these to be completed.
- Following our inspection, robust checking procedures by the senior team of matrons and specialist midwives had been put into practice. Dedicated time was allocated for senior staff to conduct compliance rounds, with inspections of all clinical areas to ensure cleanliness and checking procedures were carried out. Senior midwives provided immediate feedback to midwives. The compliance rounds were conducted daily from February to July to improve standards. It had reduced to 2-3 times per week due to high levels of reported compliance. Senior obstetricians and service managers did not participate in the rounding checks, but external rounding was provided by the trust's Chief Nurse and Director of Governance and critical care outreach team. The Head of Midwifery told us that the process had provided reassurance that cleanliness and equipment checking had improved.
- Divisional leaders reported that compliance rounds were delegated to senior midwives to give them ownership of cleaning standards. We were told that the rounds were likely to remain in place as they had become an integral part of routine checks. Senior staff highlighted that the compliance rounds generated additional paper work which required audit and data entry. The service was planning to work with their cleaning contractor to use computer tablets so that information could be recorded and reported electronically. Cleanliness, infection control and hygiene remained on the maternity service risk register and we were told that this was to ensure that improvements become completely embedded as standard 'business as usual' practice.
- We accessed four of the delivery rooms, which had been checked and were found to be clean and dust free. The shower facilities were clean. However, the shower room in the Birch suite on the birth centre was unclean with discarded tissues on the floor and blood splattered on

the tiled walls. This was shown and reported to staff immediately who stated they would get the cleaners to clean it. It was unclear when this room had last been occupied but it was at least 24 hours since the room had been in use. On our return later that day the shower room had been cleaned.

- The adjacent assessment unit was clean and the dirty portable radiator that we found previously on the last inspection was no longer in place.
- There were a number of old stickers on equipment that were torn and unclean which gave the appearance that the equipment was not cleaned sufficiently.
- The sluice room on the delivery suite was not secure, with no lock. Inside there was a box labelled 'mortuary box' clearly visible through the glass window. Sharps boxes were open and accessible and one was smeared with blood with a used intravenous set hanging loosely out of the bin. Another sharps box was open sufficiently to allow ready access to used syringes and equipment. Blood splatter was noticed on a laminated sign, and a number of portable oxygen cylinders stored in this room were also heavily splattered with old dried blood, indicating they had not been cleaned for some time. We recognise that it is unlikely patients or visitors would enter the sluice room and therefore risk of harm was low. We returned later and the blood and IV set had been removed from the sharps box. We informed staff about the blood splattered cylinders but their response was indifferent saying they 'would get someone to look at it' and this did not appear to be an urgent problem to them. This further confirmed that compliance checking had not extended to all areas of the maternity service.

Environment and equipment

- The design of the maternity unit enabled effective transfer of new born babies to the neo-natal unit in an emergency, as it was located next to the delivery suite.
- We found that equipment was ready for use, but the completion of equipment checklists was inconsistent and could be improved. The inconsistencies highlighted that a culture of compliance and checking was still in development across the maternity service.
- Records showed that the daily checking of the emergency trolley for Postpartum Major Obstetric Haemorrhage was not adhered to: in August 2015 it was not recorded on one day, and in September 2015 there were six days when it was not recorded that it was checked. In October 2015 there were two days when checks were not recorded.
- The daily checking of the adult resuscitation trolley was also inconsistent: records were incomplete for July and August. On the sheets available, between 16-31 August 2015 the trolley was not checked on five occasions, including four consecutive days. In September the trolley was not checked on six days and in October there were three consecutive days when it was not checked. In a later discussion with the Head of Midwifery, we were told that staff were expected to check equipment at least daily and was disappointed to learn that we found gaps in compliance. There is a risk that incomplete or inconsistent checks may not identify if all emergency equipment was available when needed.
- There were two resuscitation trolleys in the main corridor of the delivery suite, indicating these were for use when extra were needed. The recording of the checks of these was not consistent and there were gaps over two consecutive days when it was not recorded that checks had been completed. In addition one trolley did not have all of the expected equipment in the drawers, which could be a risk if needed in an emergency.
- In theatres, each resuscitation trolley had a checklist stating that equipment needed to be checked and 'completed with each new admission'. Checks had been recorded. In Delivery Room four the checklist was not in date sequence and the charts for checking related to the machine being in other delivery rooms, indicating that the machine moved around the unit, which made it more difficult for the service to be assured that regular checking of this emergency equipment was taking place.
- The emergency postpartum haemorrhage (PPH) trolley in the birth centre was stored in an unlocked cupboard. Drugs and fluids and pre-eclampsia boxes on the PPH trolley were unlocked. 'I am clean stickers' were on the equipment but not dated or signed. Suction equipment on the portable section was also exposed.

- We found formaldehyde stored in unlocked cupboards in the sluice room. Although this is used as a disinfectant, it could present a serious risk to human health and should be stored securely.
- We found that emergency boxes continued to be secured with surgical tape.
- The portable appliances testing, known as PAT testing of the equipment we checked was in date.

Medicines

- On Templar ward the clinical room containing drugs and IV fluids had a touchpad lock. However, the door did not always close shut and we observed a period of 20 minutes when this remained unsecure with no member of staff having to use the keypad to gain entry. Inside the room, drug cupboards and fridges were locked, but IV fluids were openly stored.
- Vials of Vitamin K were stored in insecure drawers on the resuscitation including those in the corridors. Local anaesthetic spray and acetone was also not secure on trolleys in the delivery rooms.
- IV fluids were not stored securely in the delivery rooms on delivery suite; they were in unlocked cupboards.
- We were informed by senior midwives that medicine errors including mixed dosing were identified as risks on the divisional risk register, but the maternity unit was reducing errors through the use of the new ACE system.

Records

- At the time of our inspection, the maternity service was transitioning to an electronic records system, and was using both electronic and paper records as an interim measure. In the Labour wards patient notes were entered onto the trust's 'K2' system, while observations and other charts were completed on a separate 'ACE' system. ACE was introduced into practice in July 2015. Clinical information was transferred automatically between the K2 and ACE systems.
- We examined a sample of records and found that neonatal notes and observation charts were hand written as were anaesthetic notes. This was confirmed by members of the maternity team. Having written and computerised notes makes it difficult to track the full clinical pathway of care that mothers and babies received in a timely way. With assistance from midwifery staff and in the time available it was possible to track two mother's care and confirm compliance with maternal observations on three additional women using the trust computer system.
- Midwives and junior doctors we spoke with found the record management systems covered all aspects of care and were easy to use.
- Maternal observations were taken manually and recorded onto the ACE system. The system automatically calculated MEOWS information from these observations which improved the identification and escalation of seriously ill patients.
- There were multiple computer terminals in the clinical areas and staff reported there were enough to meet their needs. All staff in the unit had access to the system, with different access levels set for different grades of staff.
- While the overall standard of recording MEOWS on mothers had improved, there remained non-compliance with the recording of baby observations. At the time of our inspection the service had not implemented a specific early warning chart for neonates (NEWS). Staff reported that this had been in development for some time (pre-January 2015) but was yet to be agreed with trust paediatricians. There was no implementation date but the member of staff who had recently been given responsibility for this hoped it would be before the end of 2015.
- The baby observation sheet had not been amended since the last inspection when it was reported that it was not being completed adequately. The chart did not have all the expected standard parameters to safely identify a deteriorating baby such as tone and colour which are often early indicators of an unwell baby. Examination of baby records during this inspection showed continued inconsistent compliance with completion of observations against the pre-set frequency of observations.
- From the sample of records we reviewed, the recording of the baby temperature on the infant record was also inconsistently completed, even though staff reported it was an expectation for this to be recorded.
- There were a significant number of unfiled records in the community midwives' office. Loose documents

including observation charts, birth summaries and other clinical information were collected in disorganised piles in a cabinet in the community office. Some of these dated back to before 2014. Staff told us they did not have time either to collate the information by individual patient nor file securely in the patient records. Most of these records related to out of area women who had given birth elsewhere, but the information would complete the maternity episode for care given in the community. This puts the trust at significant risk of not being able to adequately respond to a complaint or litigation, and could affect future care as not all clinical information would be available should a mother attend the service or hospital in the future.

Assessing and responding to patient risk

- The maternity unit had addressed the requirements of the warning notice we set following our previous inspection in March 2015. All of the hospital and community staff we spoke with were able to articulate the actions that had been taken since the last inspection. All had attended meetings about the changes and all reported the focus had been on assessing women promptly, completing observation charts, recording MEOWS and escalating clinical problems.
- MEOWS information was recorded electronically on the ACE system and was calculated automatically. The system was accessible remotely so that coordinators and doctors could access it if they were unable get to the room. Midwives were able to articulate when and how to escalate any deviations from the norm. Evidence seen on the trust's computer records showed that compliance with recording the frequency of observations was being met.
- MEOWS recording remained on the divisional risk register for inaccurate and inconsistent recording of observations. Senior service leaders reported that the new system was still being embedded and that the maternity management team was auditing it. We were told that it would remain on the risk register until there was 100% certainty that it had been addressed.
- The trust had implemented changes to its maternity triage processes and acuity scale to improve recording and recognition of deteriorating patients. All women were expected to be seen within 15 minutes of arrival, and their MEOWS checked and recorded on the computerised system.
- Processes were in place for local level quality observations of MEOWS, including new rounding processes (to audit MEOWS charts) and compliance rounds that had been daily and reduced to three times per week.
- The trainee midwives and doctors in training we spoke with were aware of protocols for escalation of ill women and babies. They were able to explain the process for crash calls and told us that there was a very low threshold for using the crash call. All of the doctors in training we spoke with reported that they felt comfortable to call a consultant or senior trainee in the case of a very ill woman. Consultants and doctors in training reported no concerns regarding delays in asking staff to attend in the room. None had faced a situation where midwives were not available.
- A Neonatal Early Warning Tool (NEWT) was not in operation. The tool is used to record baby's observations including taking their temperature within one hour of birth. A baby observation chart was in use but a NEWT is more robust. The NEWT was in development and compliance rounds checked if baby observations were made. We found inconsistent recording of both the first baby temperature and observations when a clinical risk has been identified. Of the five baby records we reviewed, none demonstrated full compliance with the trust's own standard of documentation completion. It could not be confirmed through the review of these notes that the care of babies was of a safe standard and that appropriate observation and subsequent escalation was being conducted.
- At the time of our visit, the trust's maternity risk strategy was being updated.
- The maternity service used the World Health Organisation (WHO) safer surgery checklist and compliance was audited. We were informed that anaesthetists recorded safer surgery checklist information electronically on the EPR system, but obstetricians in the delivery suite used paper records because they had added an additional check to meet the needs of obstetric patients. There were plans to

record all WHO checklist information using the electronic system. Safeguards on the trust computer records system prevented electronic records from being closed until the WHO checklist was completed. Briefings and de-briefings were witnessed and well embedded.

Midwifery staffing

- At the time of our inspection, the midwife to mother ratio was commissioned for 1:30. We were told by senior staff that no increases in establishment had been requested or offered following the previous inspection. We were also informed by senior midwifery staff that all outstanding midwife vacancies were now recruited to, including nine newly qualified midwives.
- Senior midwives could not clearly articulate the percentage and frequency of agency staff usage, but other staff reported that agency midwives were used on most shifts and that they were mostly employed on delivery suite and the inpatient wards. All of the midwives we spoke with consistently confirmed that the maternity service made every effort to use agency staff known to the service. We found that that the service was 'flexing' community midwives by transferring them from community work to the delivery suite to cope with demand. This had resulted in a reduction in temporary staff usage.
- Senior midwives reported that the skill mix in each of the clinical areas was reviewed daily and bank or agency staff were employed where needed. There was an informal approach to a manager on call for the service and this person would take responsibility for daily staffing matters. Midwifery leaders reported that it was hoped that a formal 24/7 manager on call rota would be in place by December 2015. This was under discussion between matrons and specialist midwifes.
- Midwifery staffing and recruitment were recorded as risks on the maternity risk register, but acuity, volume and complexity of patient mix were not identified as risks.
- Midwifery staffing in the Obstetrics Admissions Unit (OAU) had increased by two members of staff for all shifts in response to increased acuity. There were two midwives in OAU during the daytime and one at night supported by a midwifery care assistant. The trust was reviewing the need for two midwifes at all times in OAU.
- The maternity service was reviewing the role of midwifery care assistants across the service to identify what work they could do to free up midwives.
- At the time of our inspection, the matron for the delivery suite was on short term secondment to a trust-wide corporate role, since August 2015. The matron for community maternity services was covering both antenatal and delivery suite during this time. We were told that there were previously three matrons (the third responsible for wards only) but the roles were merged. We were told by some midwives that reinstating a third matron would help build leadership capacity in the maternity service and reduce pressure on the two incumbent matrons.
- Improvements to handover were clearly evident during our inspection. We attended two handover meetings, which were well organised and well attended. Handover was conducted twice per day at the start of each shift, and a consultant obstetrician attended with doctors in training so that information was shared across staff groups. Handover was led by a band 7 midwife and consultants and doctors in training contributed information to the discussion. We saw evidence of a comprehensive handover form, and situation, background, assessment, recommendation (SBAR) principles were used to communicate patient information in a structured way. Service leaders told us that the handover whiteboard had been redesigned to facilitate clearer SBAR discussion. Midwives told us that incidents were discussed as a key component of handover, but we did not see evidence of this as there were no incidents during the evening prior to our inspection. Senior staff, consultants and midwives reported that the service had improved handover but recognised that a full SBAR approach was still to be fully embedded in practice.
- A handover sheet was used by the midwifery team when transferring mothers from delivery to the postnatal ward. This did not full conform entirely to a standard SBAR tool but the information contained on the checklist did contain most of the elements of a formal SBAR tool. However, the record was inconsistently completed as baby observations were omitted.

Maternity and gynaecology

- All handover forms were required to be signed by the midwife handing over care and the midwife accepting the woman onto the ward. Of the three handover forms we reviewed, two were signed by only one midwife and the other had no midwifery signature at all.
- Bedside handover in postnatal care also used SBAR principles.
- Nurses from the emergency department provided external challenge and feedback on the maternity handover and use of SBAR. Senior midwives reported that they were planning to visit the A&E department to watch their handover and take back learning to the maternity service.

Medical staffing

- The Clinical Director for maternity explained that a new consultant obstetrician was appointed earlier in 2015 as lead for triage and the obstetric admissions unit. This was as a result of rapidly increasing admissions in the previous year.
- There was consultant presence from 08:00-22:00 each day, with on-call consultant cover out of hours. There was dedicated obstetric anaesthetist cover on the labour wards from 08:00-17:00 each day.
- Consultant obstetricians conducted handover twice per day at the start of each shift. Consultants and doctors in training reported that handover was effective and that use of SBAR principles was making it more consistent and succinct. Doctors reported they felt confident with this approach and had used it for some months as part of mandatory training. A higher tier doctor in training had been identified as a handover champion in the department. Senior clinicians in the department conducted an anonymous survey to investigate doctors' views on how handover was working and if it was working appropriately.
- Doctors in training reported good consultant presence and good relationships with midwives. They told us that they felt well supervised and that consultants were approachable. Doctors in training reported variable work intensity, with some relaxed periods and some very intense shifts. However, rotas were seen to be well managed.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

The vision and strategy for maternity services was not documented or fully understood by staff. However, we found a cohesive team environment where staff felt supported by their managers and peers. There was recognition by all staff of the collective response to address the concerns of the previous inspection.

We found some progress against the previous warning notice for governance and assurance of the maternity service, but there was still a need to improve and strengthen governance structures and reporting systems. Governance information was reported adequately at appropriate meetings, however external challenge by the trust's centralised governance team needed to be further embedded and supported by staff in the maternity unit to ensure appropriate support and challenge.

Leadership training was planned for senior staff within the unit, to improve knowledge and skills in this area.

Vision and strategy for this service

- There was no clearly defined vision or strategy for the maternity service. The Head of Midwifery told us that there was agreement between the senior midwifery and consultant team on the vision of the service, but it was not written or shared with other members of the maternity team. Senior leaders within the service were not able to articulate a vision beyond making the hospital the top rated maternity service in the country by women and ensuring that staff were looked after.

Governance, risk management and quality measurement

- We found progress against the previous warning notice for governance and assurance of the maternity service. However there was scope for improving and strengthening governance structures and reporting systems further.
- A combined action plan that brought together all the issues raised by the CQC, CCG, external reviews carried

out following the maternal deaths and the outcome of the three maternity summits led by the CCG was in place. The combined action plan was monitored by the trust board and the CCG.

- The divisional leadership team was not able to clearly articulate who was responsible for line management of the Clinical Director for maternity. In terms of day to day line management and reporting it was not clear to staff if the Medical Director or Divisional Operations Director was responsible. At the time of the inspection, the Clinical Director for maternity had a dual role as the associate medical director for the Surgery, Women and Sexual Health (SWSH) division which was not best practice for good governance. It did not provide for sufficient objectivity and external challenge.
- There were formal processes for reporting risks. Staff within the maternity unit were required to escalate immediate risks in discussion with their line managers. Risks were then escalated to the head of midwifery and a risk assessment form was completed. The risk was then reviewed by the risk midwife against the trust's criteria for adding information to the unit risk register.
- The maternity unit 'dashboard' had been redeveloped since our previous inspection, which included parameters or thresholds for all clinical outcomes including for the number of maternal readmissions and the rate of puerperal sepsis. A revised parameter was set for the definition of massive obstetric haemorrhage from two litres to 1.5 litres to ensure a more rapid response and in line with guidance.
- The Head of Midwifery reported that the dashboard was updated monthly and scrutinised by the senior team and submitted to the trust board. There was a dashboard exception report which submitted all 'amber' and 'red' risks to the weekly divisional management and monthly maternity risk management meeting. A narrative explanation was provided to the exception report by the Head of Midwifery, which also accompanied the dashboard when shared at board level. We reviewed the dashboard. The identified risks on the dashboard included patient observation recording inaccuracies, staffing and the quality of incident information and data. Action plans were in place for each of these risks.
- The foetal loss case reviews were undertaken by the bereavement midwife, consultant obstetrician, and clinical governance midwife. The status of the reviews were closely monitored as the reviews were taking longer than planned. The issues were identified on the maternity risk register which was reviewed at the monthly maternity risk management review meeting (MRMR) as well as the Trust Management Board.
- The maternity unit risk ratings were reviewed against local and UK clinical guidelines. External risk benchmarking was also conducted in partnership with the SCLG and the pan-London labour wards lead group, which was attended by labour wards from all London maternity units. There was limited evidence of other benchmarking activity, for example against other maternity services.
- The MRMR was attended by the clinical director, head of midwifery, risk manager, midwives and matrons. The monthly meeting was chaired by the divisional operations director following our previous inspection to provide more challenge. There was an action log and recorded minutes to ensure that actions were recorded staff were held to account. There was a set agenda to review the unit risk register, incident reporting trends and themes, the maternity dashboard, serious incidents and root cause analysis reports. A labour ward forum fed into the MRMR meeting.
- Weekly Complaints, Litigation, Incidents and PALs (CLIP) meetings were chaired by the Associate Medical Director who also had the role of Clinical Director for maternity and attended by the divisional governance lead, band 7 ward leaders, matrons, leads for ITU and theatres. The meetings were used to review all incidents and complaints across the division. We were told that service managers did not regularly attend this meeting.
- A monthly performance review was also in place, attended by the trust's Medical Director, Chief Operating Officer, Finance Director and Chief Nurse and Director of Governance. The SWSH divisional operations director reported information from the MRMR meetings, which included quality and performance metrics such as falls, finance, and incidents.
- We attended a weekly divisional managers' meeting. All five service managers from the SWSH division attended and the meeting was chaired by the divisional

operations director. There was monthly rotation of agenda items and governance was the main topic during our inspection. A quarterly governance report for maternity and a wider divisional monthly report were reviewed. The overarching divisional summary was led by the trust's interim quality and patient safety manager. This covered the dashboard for all of SWSH. We observed a good overview of risks and performance metrics in the maternity unit, but there was limited challenge from other managers attending the meeting. We heard that the interim patient safety manager had not been invited to sub-divisional monthly meetings, which meant that some risks on the divisional risk register had not been fully reviewed as the information had not been provided by the divisional managers. The interim patient safety manager needed to share the risk register with responsible people in the division to ensure they were updated in a timely way.

- The trust operated a centralised governance team, with a patient safety manager providing input and challenge to each division on governance matters. The structure within the SWSH division included senior posts for managing human resources and finances, but an equivalent post for governance was provided externally by the trust-wide team. A strengthened, more embedded governance presence, more aligned to the division could provide for greater scrutiny and acceptance of this important role.
- Our review of meeting minutes found no evidence of pharmacy input to divisional governance meetings.
- Obstetric anaesthetists held clinical governance meetings separate to obstetricians, but a joint obstetrics and anaesthetics meeting was held every two months to share learning between clinical staff.
- Senior staff in the neo-natal team reported a constructive and collegiate relationship with their colleagues in the maternity unit. Although maternity and neonates were located in separate divisions, with separate governance structures, senior staff reported that the interface and communication between obstetrics and neonates was very good and clear. Both units had identified governance challenges because of their separate status, so they set up new meetings to facilitate better links. The neo-natal clinical lead reported that joint perinatal meetings were a very open exchange of views and learning, and the monthly maternity neonatal forum reviewed audits of NEWS scores. There were also good informal links between obstetrics and paediatrics, with open dialogue between staff in the two units such as a briefing note email which was sent from the neo-natal team to the maternity unit twice per day with an update on their status. Risk midwives attended the Special Care Baby Unit governance meetings to provide information from the maternity unit and then fed back information from the neo-natal team to staff in maternity.

Policies and audits

- There was a specific maternal collapse policy in operation, following our previous inspection. We reviewed the new the policy and found it covered all aspects of care.
- National institute of health and care excellence (NICE) guidelines (CG37) for puerperal sepsis had been implemented.
- New guidance on obstetric admissions had been produced to organise the process for reviewing MEOWS on arrival and escalation protocols for very ill women.
- Individual policies for maternity were discussed and approved at MRMR meetings. The new policies were not reviewed by more senior level board meetings.
- The unit had an audit midwife who was responsible for ensuring national guidance was reviewed and mapped against the trust's existing policy. For example guidance from NICE or the Royal College of Obstetricians and Gynaecologists.
- The SWSH division quality improvement programme produced a priority list of national and local clinical audits, service evaluations and other projects aimed at improving care.
- There was a clinical audit plan for the year that was reviewed at various governance meetings.
- Specialty clinical governance meetings identified areas for improvement based on national and trust requirements, local risk triggers, and warning signs.
- We found some improvements in the clinical outcomes demonstrated by audits. Sample audits of patient outcomes between August and September 2015 highlighted that 91% women had active management of third stage of labour. 95% of cases had complete

delivery of placenta. 60% of women delivered during day shift. One third of patients had assisted vaginal delivery. 14% of patients experienced first degree perineal tears, and 32% experienced second degree tears.

Leadership of service

- There were plans to introduce a leadership development programme for senior maternity staff including midwives and obstetricians to improve leadership skills across the service.The proposed leadership programme was seen as a means of identifying the gaps in the maternity service leadership, culture and support and challenge systems. At the time of our inspection a start date for the programme and membership had not been confirmed.
- Health Education North Central London had granted funding for leadership training and joint working training, which was due to start in December 2015. The training was available for band seven midwives, senior clinicians and matrons.
- Doctors and midwives reported that the trust chief executive was involved in giving feedback after our inspection and participated in discussions about improvements to the service.
- Some midwives commented that the reduction in matron posts from three across the service to two had resulted in a reduction in support for all staff and more work for band seven midwives, particularly on the wards. It was reported that the two matrons were stretched and were not always able to provide appropriate support to other team members. Some midwives felt that this was compounded by an unbalanced sharing of the work load with other band seven midwives on delivery suite.

Culture within the service

- There was recognition amongst all of the staff we spoke with of the impact of the previous two years, which had included the 'unhappy midwives' campaign and a high level of external challenge and scrutiny.
- Service leaders reported a very cohesive team within the maternity service, and cited the team's collective response to our findings and what needed to be done to address shortcomings. They told us that staff had worked together to make changes such as use of SBAR and recording MEOWS. Senior staff had not received negative feedback about the changes. The Head of Midwifery told us that the senior team was proud of the maternity team for their commitment and hard work.
- The Clinical Director reported a tangible difference in staff morale since the inspection, with positive feedback from staff and service users.
- Consultants contributed that all staff were dedicated to providing a good service for women and their families, but recognised that the unit was a "hard work environment" which required all staff to "knuckle down to enjoy the job". The high volume of work, diversity and complexity of patients was cited as potentially stressful for consultants and doctors in training alike. Consultants also told us that us that our findings were a "shock to the system" but that the service leadership was open to change and saw it as an opportunity to improve.
- Doctors in training told us that they worked with very supportive consultants who were visible and accessible, with a flat hierarchy. They did not experience a blame culture and felt comfortable to ask questions. They found a positive and supportive training experience within the maternity unit. They told us that consultants provided a supportive environment and they had no concerns about the quality of training.

Public engagement

- We were told that the trust engaged with women using the maternity service through surveys such as the Friends and Family Test, PALS and complaints received. There was a low response rate to the Friends and Family Test, but with positive ratings.
- The CQC maternity survey in February 2015 (published December 2015) showed that the service performed worse than other maternity services for care during labour and birth. The service was similar to other services for staffing during labour and birth and care in hospital after birth. However, survey results had improved for cleanliness and confidence and trust in midwives when compared with the previous CQC maternity survey published in February 2014. An action plan was to be developed to improve performance across indicators.

- To prepare mothers and their partners for the birth of their baby ward tours took place weekly in the early evenings, midwives familiarised women and their partners with the environment and were available to answer any questions.
- There was a poster at the entrance to Templar ward which presented 'you said, we did' information on patients' feedback and actions taken.

Staff engagement

- Midwives of all levels we spoke with enjoyed working at the service. The local supervisory audit of midwifery carried out in April 2015 found good team leading, engagement and leadership by supervisors of midwives.
- The most recent quality visit report by Health Education North Central and East London in February 2015 showed that obstetrics and gynaecology doctors in training enjoyed their experience at the hospital, and numerous trainees stated there was a family atmosphere. It was felt that at times some trainees may struggle more than others, particularly following serious incidents. Workload was also reported to be relatively high and was covered by a small team – therefore any clinical shortcomings would easily be identified. The visit team was pleased to find that there was a strong positive culture of safety and teamwork within the department. Simulation training had been introduced into the trainees' induction and trainees described it as being very good. All of the doctors in training said that they would recommend their posts.
- The General Medical Council's 2014-15 National Trainee Survey of doctors in training found no bullying and undermining or patient safety comments for the maternity unit in 2014 or 2015. There were no negative outliers generated in 2015. Overall satisfaction improved significantly, particularly for foundation year 2 doctors. In 2013 and 2014 it was a negative outlier.
- The trust distributed an all staff e-newsletter, which had replaced the trust-wide governance newsletter. Additional communications were sent to all staff directly by the trust Chief Executive and separately from the Medical Director and Chief Nurse and Director of Governance.
- Staff had the opportunity to provide feedback daily at handover meetings as well as at weekly meetings between sister and ward staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(a): Good governance The trust must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity maternity and midwifery services (including the quality of the experience of service users in receiving those services).