Care Quality Commission

Barts Health NHS Trust

Newham University Hospital

Quality Report

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Date of inspection visit: 14 to 15 January 2019
Date of publication: 05/04/2019

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	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Following our last inspection in September 2018, we rated Newham hospital maternity as inadequate overall.

We had serious concerns that systems to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. We also had concerns that governance systems and processes were not operating effectively. We served the trust with a Section 29A Warning Notice, served under Section 29A of the Health and Social Care Act 2008, on 18 October 2018. The notice required the trust to make significant improvements by 16 November 2018 and to send us details of how they were making improvements.

The trust responded on 16 November 2018 with an explanation of action taken to respond to the immediate safety issues and an improvement plan to address the specific concerns included within the warning notice.

We conducted this follow-up inspection on 14 and 15 January 2019. The inspection was unannounced. The inspection focused mainly on the issues identified in the warning notice where significant improvement was required in improving leadership, strengthening governance and oversight, engaging staff and addressing safety concerns specified in the warning notice as detailed below.

Governance and systems to assess, monitor and improve the quality of services:

- Improving data quality and data governance processes
- Improving complaints and SI processes
- Improving learning from complaints and incidents
- Improving standards of documentation
- Ensuring maternity support workers are trained in carrying out observations
- Improving governance of change
- Improving security of patient information
- Improving understanding of governance by junior staff

Providing safe care and treatment:

- Ensuring clinical equipment was clean and fully checked.
- Ensuring high standards of hand hygiene
- Ensuring immediate labelling of specimens
- Strengthening the process for providing assurance of equipment checks
- Ensuring proper segregation of waste
- Ensuring medicines were stored in locked fridges and replacing fridges in poor condition.
- Ensuring ward managers supported and supervised maternity care assistants and support workers

The trust had achieved progress in addressing our concerns; however, there was still work to do to deliver and sustain progress. We judged that the requirements of the warning notice had been met as far as possible within the short timescale.

We rated Safe and Well led as requires improvement and requiring ongoing effort to achieve sustainable change.

Summary of findings

We saw outstanding practice in the leadership and drive shown by the acting head of midwifery.

The trust should:

- Continue to monitor all areas of the improvement plan, even when some stages are apparently complete, to ensure all new processes are fully embedded.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Maternity	Requires improvement		This was a follow up inspection to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in October 2018. We did not inspect all domains, but focused on Safe and Well led. The trust had reacted quickly to the warning notice, within the timescale. Within a month they had drawn up an action plan and had put in place new systems to deal with the main concerns in safety and governance. Many senior staff were doing everything in their power to take the service forward. However, it was too early at this stage, to show the impact of improvements in every area. We did not identify any breaches of regulation. We rated the two domains as requires improvement to reflect the fact that audits were showing improvement as a result of recent changes, but that it was too early to judge sustainability and longer-term impact.

Care Quality Commission

Newham University Hospital

Detailed findings

Services we looked at
Maternity (inpatient services);

Detailed findings

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Background to Newham University Hospital

Newham University Hospital is part of Barts Health NHS Trust. It provides maternity services to women in the London Boroughs of Newham and Barking. In 2017/18, Newham Hospital had 6,204 births.

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

There is one permanent theatre. A second theatre is available for elective caesarean sections and can be staffed quickly at other times for emergencies.

Larch ward, on the ground floor, has two sections, an 11-bed antenatal ward and a postnatal ward with 33 beds. There are two bays for transitional care.

Please refer to previous full inspection report from September 2018 for further background information if required.

Our inspection team

The inspection was overseen by Terri Salt, CQC Head of hospital Inspections for London.

The inspection team included a CQC inspector, a consultant obstetrician and senior midwife.

How we carried out this inspection

At the last inspection in September 2018, the maternity services were rated as inadequate for the safe and well-led domains and requires improvement for the effective, caring and responsive domains. Maternity was rated as inadequate overall. We inspected all inpatient areas of the maternity service on this inspection, but did not inspect community midwifery.

In response to the specific concerns at the previous inspection, we focused on, Is the service safe? And Is the service well-led?

- We reviewed information publicly available and data from our most recent comprehensive inspection.
- We conducted an unannounced inspection on 14 and 15 January 2019.
- We observed meetings, observed clinical care and reviewed women's care and treatment notes.
- We reviewed clinical governance and risk management information including notes of governance meetings.
- We spoke with over 40 members of staff across all grades and roles.
- After the inspection we asked the hospital to submit data to establish performance in standard areas within the focus of the site visit.

Maternity

Safe	Requires improvement
Well-led	Requires improvement
Overall	**Requires improvement**

Information about the service

Newham University Hospital provides maternity services to women in the London Boroughs of Newham and Barking. In 2017/18, Newham Hospital had 6,204 births. Most maternity services are located together in one purpose built section of the hospital, where ante-natal, intrapartum and postnatal care is provided. The booking and antenatal clinics take place at the other end of the hospital where there are four ultrasound rooms.

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

Staff have access to two obstetric theatres 24 hours a day. Larch ward, on the ground floor, has two sections, an 11-bed antenatal ward and a postnatal ward with 33 beds. There are two bays for transitional care. There is a further bay that staff can open if the ward is very busy. Six single rooms can be used by women with a medical need, or as amenity rooms for which a fee is paid.

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

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

Summary of findings

This was a follow up inspection to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in October 2018. We did not inspect all domains, and focused on Safe and Well led.

The trust had reacted quickly to the warning notice within the timescale. Within a month they had drawn up an action plan and had put in place or commissioned systems to deal with the main concerns in safety and governance. Many senior staff were doing everything in their power to take the service forward. However, it was too early at this stage to show the impact of improvements in every area.

Our meetings with the managing director and the acting head of midwifery showed they were taking the concerns in maternity seriously. Both were keen to see the appointment of an experienced Head of Midwifery as soon as practicable to maintain the momentum of improvement.

Many staff understood there were issues in the maternity service, and were keen to address them.The trust had made many staff changes since the last CQC inspection, including a new managing director and a new director of nursing at Newham hospital and a new divisional structure across the trust including a clinical leader of Women's and Children's Health Division at Newham. This strengthened multidisciplinary leadership. The trust Director of midwifery was acting as Head of midwifery as a temporary measure to initiate change to ensure safety. Senior staff recognised that the workplace culture was a long-standing issue and amongst other things they developed, with staff, a charter of behaviour within the maternity service that was in line with trust expectations. Although some items on the quality improvement plan were marked as

complete, senior managers were aware that the measure of success would be in how well standards were maintained over the longer term. They would need to maintain focus and momentum to ensure continued compliance.

We did not identify any breaches of regulation. We rated the two domains as requires improvement. This reflected the fact that audits were showing improvement as a result of recent changes, but that it was too early to judge longer term impact and sustainability.

Are Maternity services safe?

At our last inspection we were concerned about the safety of patients for the following reasons:

- There was poor compliance in following up learning from incidents to prevent recurrence.
- Training was not making the intended impact on standards of clinical practice and record keeping.
- The quality of clinical records did not meet expected professional standards and notes were not stored securely.
- There was a risk of the spread of infection because of poor hand hygiene practice and poor cleaning of clinical equipment.
- Blood samples were not labelled promptly and there was a risk they could be mixed up
- Checking of emergency equipment was lax and staff were not spotting items that were missing or out of date.
- Waste was not properly segregated, some sharps bins were overflowing and others were open and not secured to the wall, so could tip over leading to injury or infection
- Some rooms containing non-clinical fridges were too warm to maintain the correct temperature, some fridges were not locked and some fridges were in poor condition.
- Maternity care assistants were not given clear guidance on taking observations of women which led to inconsistent recording of the Modified Early Obstetric Warning System (MEOWS).

During this follow up inspection we found:

- **There were still not enough midwives and there were shortages in the week before, and during our inspection. The service was operating at a midwife to birth ratio of 1:25 through using bank and agency staff, but there were midwife vacancies and the midwife sickness rate was double the trust target.**

- **Despite a focus of checking, cleaning and restocking clinical equipment it was clear from incidents and from our observation that further improvement was needed to ensure the right equipment was always available and clean.**
- **The level of consultant presence on the delivery suite was lower than expected for a unit with a complex case mix, and 6000 births. A high proportion of consultants took annual leave at Christmas, leaving a senior team of bank locums on Christmas day and Boxing Day. The locum consultants were on call for 24 hours.**
- **Triage tools were not always fully completed.**
- **The service had revised elements of its mandatory training from 1 January 2019 to take account of newly identified needs, incidents and complaints, but it would not be possible to assess the impact of this for some months.**

However:

- **There was now established access to a second theatre with dedicated staffing.**
- **Rooms that were found to overheat now had air conditioning and all damaged fridges had been replaced.**
- **Waste management had significantly improved.**
- **The service had improved its control of infection through better hand hygiene.**
- **Mandatory training on appropriate standards of documentation, waste management and training for maternity care assistants on taking observations had taken place outside the annual training cycle to make immediate improvements.**
- **There was some evidence of recent improvements in written records of patients' care and treatment in the delivery suite and postnatally, including more contemporaneous recording. Records were now stored securely and available to all staff providing care.**
- **Staff generally completed and updated risk assessments for each woman. They had systems to respond to changing risks, and documentation was being completed better than at the previous inspection.**

Mandatory training

- **The service had revised elements of its mandatory training from 1 January 2019 to take account of newly identified needs, incidents and complaints. Mandatory training on professional standards of documentation, on waste management and training for maternity care assistants on taking observations had taken place outside the annual training cycle to help make an immediate impact.**
- During our last inspection, we raised concerns about the training provided both to midwives and to maternity care assistants.
- Mandatory training updates for midwives had been revised and now also took account of incidents and complaints. The new programme was starting in January 2019. The new programme and dates were on display for staff. Topics included safety systems and practices in antenatal screening, perinatal mental health, fire safety, waste management and customer care. Training on life support had been changed to ensure all staff had practice in adult and neonatal life support through simulation training.
- We were told that skills and drills were now carried out on wards as well as on the delivery suite, although these were run more frequently on the delivery suite.
- In response to the warning notice, there had also been training outside the annual statutory and mandatory training cycle. For example, maternity care assistants had undergone training to help carry out effective routine checks and the reasons for routine checks, for example that proper catheter care was important to prevent kidney disease. The "Message of the week" during our inspection reminded staff to add up scores on the charts for Modified Obstetric Early Warning Scores (MEOWS) emphasising that an elevated temperature could be a sign of developing sepsis. There

had also been training on appropriate professional standards of documentation and in waste management. The team were to develop Quality assurance spot checks on completion of observation charts.

- Some doctors in training said they were not clear whether their mandatory training was monitored.
- All staff had training in sepsis and there was a policy for sepsis management in place.
- The service had undertaken a full training and competency assessment of all maternity support workers to ensure they were competent in carrying our observations on mothers and babies. They had also received training in point of care testing and this training would in future be refreshed yearly.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff understood the importance of using interpreters where women themselves did not speak English.
- It was safeguarding week during our inspection. Staff attended a presentation about a recent local serious case review. This emphasised the importance of identifying safeguarding concerns, which were not always obvious, and highlighted the risks of overlooking them. The case review had revealed a lack of clarity about where and with whom a mother lived. Part of the message of the week extracted from this case reminded staff to check the address of women brought in by ambulance from an address different from their registered address, to enquire about the reason for the change and to escalate any concerns quickly.
- Information about how to report a safeguarding concern was displayed in staff rooms. Staff were aware of the importance of using interpreters, including to help identify safeguarding needs.
- The latest "Message of the week" also reminded midwives to ask all women, regardless of ethnicity, religion and culture about cutting or alteration to the genital area including piercing, and to record this in the woman's notes. This question should be asked at booking and, where appropriate, concerns should be escalated.
- Perinatal mental health was covered in mandatory training.

Cleanliness, infection control and hygiene

- **The service had improved its control of infection.** Staff kept their hands clean and there was sufficient personal protective equipment. A member of the infection control team was supporting maternity in improving infection control practice and carrying out checks.
- At our inspection in September 2018 we had raised concerns that staff did not regularly wash their hands or use hand sanitiser when moving between patients and clinical areas, and hand sanitisers were poorly located.
- On this inspection we saw good hand hygiene, and staff actively challenging visitors to clean their hands. Dispensers were better located, including outside every delivery room and all were full. Staff were carrying out 10 hand hygiene observations in every area each day to monitor standards.
- Our last inspection also identified concerns that clinical equipment, including resuscitaires and suction units, were not consistently clean. The cleaning of resuscitaires had improved. Although we saw improvements in cleaning of clinical equipment and premises by comparison with the previous inspection, there was still improvement needed.
- Domestic cleaning compliance on the postnatal ward was 92% in December 2018. Some windowsills were not clean on that ward, particularly in single rooms and there were discarded leaflets and posters on the sills in several areas. We observed inconsistent use of "I am clean" labels on the antenatal and postnatal wards, and saw dust at both high level and low levels. We noted that a spot check on the antenatal ward's emergency trolley on 4 January 2019 had made suggestions about damp dusting which appeared not to have been actioned. There was dust on the portable suction collection chamber and the top of the trolley itself contained remnants of tamper-evident tags. Our observations were in line with the findings of cleaning audit in late January 2019. Improvement was slower in wards than on the delivery suite.

- In September, we found many dispensers for sterile gloves, aprons and detergent wipes had been empty. On this inspection most were well stocked, with one of two omissions on the postnatal ward.
- On this inspection, compliance with uniform policy was better, although some staff did not follow the policy that headscarves should be placed inside clothing and at least one doctor did not adhere to the trust's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infection.
- We noted that lockers were available for staff shoes. Information about standards of dress for non-clinical staff was on display. We were told staff were empowered to challenge colleagues on uniform and encouraged to maintain a consistent approach.
- There was still evidence of pest control in the antenatal clinic area but staff stated this was being adequately managed.

Environment and equipment

- **There was now established access to a second theatre with dedicated staffing. Rooms that were found to overheat on the previous inspection now had air conditioning and damaged fridges had been replaced. Waste management had improved.**
- At the last inspection we had concerns about the availability of a second obstetric theatre in emergencies. Until just before the September 2018 inspection only one obstetric theatre had dedicated staffing. At this inspection there were now funded arrangements in place to ensure that a second, and if necessary third theatre could be quickly staffed at any time. Planned caesarean sections now took place in the second theatre with dedicated obstetric equipment. The new arrangements (dated October 2018) were displayed in the handover room on the delivery suite and included clear scenarios for theatre opening and who to contact. Staff considered it was "A great success" to have a separate anaesthetic team for a second theatre.
- At the previous inspection, the temperatures in some parts of the unit were uncomfortably warm; mainly smaller rooms and kitchens. On this inspection, we found air conditioning had been provided in many of these rooms and other rooms were due to have this installed later in January 2019. Fridges in poor condition that we had seen previously had been replaced, and better temperature regulation should now ensure fridges maintained their correct temperature. Staff reported improvements to the working environment since the CQC warning notice.
- At the previous inspection, we found staff did not segregate waste using the correct colour-coded sharps bins and smaller containers were not fixed to prevent spillage. Correct waste segregation had improved on this inspection. Staff had received training from the clinical waste team and there were posters in most sluices showing which container to use. Staff had been given small cards to remind them. We found bins ready for use in all clinical areas, and the small sharps bins on wards were attached to the wall. There was regular collection of full bins and new containers were assembled and labelled as soon as one was closed. Shift coordinators were monitoring this.
- At the previous inspection, we had had concern about the storage of emergency equipment and the consistency of checking processes. As part of the trust response to the warning notice, we found that senior staff were reviewing assurances on all daily routines and working with staff to ensure checks were properly carried out and supervised. Spot checks were done and we saw staff had generally responded well to the change in procedures. Emergency trolleys were checked twice a day and medicines and equipment were in date. Staff were allocated checking responsibilities daily and were required to record missing equipment and date of replacement. We found on this inspection that the quality of checking had improved. There were new lockable emergency trolleys with equipment to manage postpartum haemorrhage. This responded to the concern on our previous inspection that open trolleys presented a risk that items could be removed and would not be fully stocked in an emergency.
- However, we found staff did not replace missing equipment on trolleys on the postnatal ward immediately. Blood bottles missing were recorded as missing on five consecutive days. The checking folder for the emergency trolley in the antenatal ward was disorganised and contained old, unarchived documents. We also checked "hypo boxes" containing glucose products for use in cases of low blood sugar.

The checking sheet in the box on the postnatal ward was blank. The box on the antenatal ward had been checked daily until two days before the inspection. We noted there was inconsistency between the contents list displayed on the wall of the clean utility room where the box was kept, and the list within the box.

- Not all beds on the antenatal and postnatal wards were in use although we saw from incident reports that the postnatal and antenatal wards were sometimes full. Staff were not able to tell us in what circumstances the unused beds would be opened. After the inspection the trust sent us a protocol drawn up for the opening of these beds on instruction. The midwife in charge or manager on call could authorise this in specific circumstances, and if a midwife could be found to cover the bay.
- Most electronic items we saw were in date for servicing and electrical safety testing. We found four blood pressure machines overdue for re-calibration (due December 2018). Three were in the antenatal clinic and one on the postnatal ward. We drew this to the attention of staff who had not noticed and did not take them out of use.
- There continued to be some maintenance problems with toilets/wash basins outside the antenatal clinic and in the four bed MAU bay. We noted that water outlet flushing in one room on the postnatal ward had not been carried out in the four days prior to the inspection but had been done daily before that.
- The room containing the medicine freezer on the postnatal ward was not locked, although the freezer was locked. The room itself was untidy and contained a half empty medicine bottle which may have belonged to staff. We noted three or four missed checks of the temperature of the milk fridge on the postnatal ward in each of the three weeks preceding the inspection.
- There was no housekeeper on the antenatal ward. The same types of items were stored in several different areas in the clean utility room which staff said made stock control and rotation more difficult.

Assessing and responding to patient risk

- **Staff generally completed and updated risk assessments for each patient. They had systems to respond to changing risks, and documentation was being completed to a better standard than at the previous inspection. Triage tools were not being fully completed.**
- Concerns about consistent use of modified early obstetric warning score (MEOWS) were raised as part of the warning notice. These observations are designed to allow early recognition and escalation of deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature. Training had now been provided for maternity care assistants on recording observations and there was information on display in the postnatal ward about appropriate frequency of observations e.g. four hourly observations for all patients with specific risks such as postpartum haemorrhage, post caesarean section or stepped down from HDU. A sample of patient notes on the postnatal ward showed more regular measurements and that scores were added up. MEOWS charts were audited to assess compliance.
- The previous inspection had found inconsistency in recording 'fresh eyes', a safety check where a second midwife reviews the CTG trace to reduce interpretation error and to support timely intervention when indicated. The notes we looked at on this inspection showed two hourly fresh eyes checks were being carried out in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth). The form prompted the midwife to check whether the woman's baseline had changed. We also saw that in the birthing unit, the service was using 'fresh ears' for intermittent auscultation (where midwives use a sonic-aid to listen to the fetal heart in between contractions to determine the baseline,and monitor fetal wellbeing). Midwives completed a sticker confirming their check.
- At the previous inspection, we found staff did not know where to record assessments of the risk of venous thromboembolism (VTE), patients' risk of developing a blood clot. Staff we spoke with on this inspection knew how to record this within the CRS electronic system and training of staff in CRS was ongoing until March 2019. The training would reduce the risk that a woman's VTE status would not be recorded in the correct location.

However, a cross-trust group was reviewing whether using CRS was the best method to manage maternity data across all the trust's maternity services in the medium term.

- Women in labour could attend the dedicated maternity triage 24 hours a day, seven days a week.The patient notes we looked at on the postnatal ward showed triage assessment tools were still not always fully completed and we were aware that triage was a theme of incidents in December 2018.
- To minimise the risks to women needing urgent transfer to the delivery suite from triage, two rooms were reserved for urgent cases except in the case of imminent birth, where woman were transferred to Room 57 on the Ground floor where a midwife from the delivery suite or birth centre would be called downstairs to deliver the woman. Information about this arrangement was on the bottom of the obstetric triage tool.
- The trust continued to ensure that risks for women undergoing obstetric surgery were reduced as staff followed the five steps of the World Health Organisation (WHO) surgical safety checklist for women having a C-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. The process was audited. We were told that consultants attended difficult deliveries.
- On the previous inspection, incomplete records meant that when a woman was transferred to another part of the service staff were not always made aware of their care needs. We saw that senior staff were working on ensuring smooth transfer from one part of maternity to another; for example, from the delivery suite to postnatal ward and postnatal ward to the community midwives. Key information on transfers from the delivery suite was recorded on a sheet requiring completion of the situation, background, assessment and recommendation. Consistent use of this sheet was not yet embedded. The service had recently identified weaknesses in discharge arrangements to the community and had set up a sub-group to make the system more robust. In the meantime, staff were contacting postnatal women by telephone within 48 hours of discharge, to check if they had had a visit from the community midwife.
- Some staff expressed the view that pressure on midwives and doctors deriving from the complex case mix of women on the delivery suite was a safety risk.
- Language barriers, where women and their partners did not speak English, was now recognised as a risk which we saw was being mitigated through routine use of interpreters and language line. We saw an interpreter explain procedures to a woman with a complex medical condition in the obstetric theatre.

Nurse staffing

- **The service was operating at a midwife to birth ratio of 1:25 but there were midwife vacancies and the midwife sickness rate was double the trust target.**
- Staffing fill rates in November 2018 had averaged 90% on the delivery unit. At the time of inspection there were 24 midwife vacancies in the hospital and 6.7 in the community. The team could use agency and bank midwives to cover sickness and vacancies.
- Shortfalls of staff on the day were mitigated through the escalation process to ensure safety. On the first day of inspection, the service was short of two midwives on the delivery suite and two on the postnatal ward. One the second day of inspection - a bank midwife called in sick mid-morning, rather than at 6.30am as per policy. We heard staff describe the correct reporting procedure on the telephone. We saw that the effect of cancelling shifts with late notice had been discussed in a safety briefing.
- There continued to be a higher level of sickness than the trust target of 3%. In maternity the sickness rate was about 6% for both hospital and community midwives. Staff were seeking to address this in part through improved working conditions and the maternity team were to receive dedicated support from the human resources unit in taking stronger action on sickness absence than had been common in the past. Staff shortage was seen to be one of the top five themes of incidents in November and December 2018.
- The rotation of staff planned at the last inspection had been put on hold while the hospital team regained staffing stability
- A birth-rate plus assessment had been carried out by the trust. The agreed midwife to birth ratio was now 1:25

across the service. On the delivery suite the ratio was 1:28. There was a shortfall of five maternity support workers (MSWs).There was a rolling recruitment programme for permanent and bank midwives and to fill vacant MSW posts and mitigate short term sickness.

- There were three matrons in the midwifery structure, one for inpatients, one for the delivery suite ward and one for community midwifery. Two of these were new appointments. There were consultant midwives for safeguarding and education, and a senior midwife for governance.
- There were two triage midwives and two in the maternity assessment unit (MAU) during the day, and one midwife in triage 24 hours a day. Some doctors felt that the assessment unit/triage was sometimes overwhelmed with women waiting to be seen.
- There was one bereavement midwife on the Newham hospital site who covered the hospital emergency service, gynaecology, maternity and the neonatal unit, some 200 women a year who had a stillbirth, neonatal death and miscarriage. The stillbirth rate was 5.3% which is just above the national average. She saw women/parents in their own homes and on the hospital site. As we had noted at the last inspection, this was a large remit and there was no cover when the post holder was on leave, and she followed up cases on her return. We learned at this inspection that at the other hospitals in the trust the bereavement midwife role covered maternity only.

Medical staffing

- **The service had lower consultant presence than we might have expected given the complex case mix and high number of births.** Consultants considered there was shortfall of four medical trainees which impacted on them and for which a business case had been made.
- Consultant cover had been a concern at previous inspections. Although the Royal College of Obstetricians and Gynaecologists no longer specify a fixed number of hours, cover should be in line with case mix, the judgement is left with hospitals to decide the level of cover appropriate for the size of the unit and case mix. In the daytime a consultant was normally present in the unit from 8am to 10pm including on public holidays.
- During the day there was an SHO in each clinical area. Consultants recognised that junior doctors were sometimes stretched out of hours when they were also responsible for the maternity service, the emergency department and gynaecology. This meant they could not always be present on the delivery suite. A feasibility case had been drawn up for extra SHO cover and the hospital were funding an extra SHO at night, as a cost pressure for the site, at the time of the inspection. . However, the business case was unclear about the level of decision making they needed from additional medical staff.
- We were told the doctors covering MAU and the emergency department were registrar grade and provided dedicated cover Monday to Friday from 8.30am to 5pm. Outside these hours it is covered by the registrar on call for gynaecology. The trust told us after the inspection that the medical fill rate at January 2019 was 91% and turnover was 4%. The doctors' annual sickness rate was low at 2.2%.
- We had noted an incident reported on 21 December 2018 showing gaps on the doctors' rotas on 23, 24, 25 and 31 December. These gaps, caused mainly by leave but also by sickness, had been offered for locum cover, but were not filled at that date, only two days ahead of the first date. In reviewing the medical rota we saw the situation was partly mitigated by staff cover from the internal bank. Nonetheless it was poor planning for five of the 18 consultants to be on annual leave the week before Christmas, and seven to be annual leave the whole of Christmas week. In both those two weeks, other consultants were also on leave for one, two or three days. Furthermore, the rota showed three consultants were on leave during both Christmas and New Year weeks, one of these having an additional week off. This was expensive in terms of locum use, set a poor example to other staff and carried a safety risk.
- In a maternity unit with the case mix of Newham it is significant risk for any consultant, and especially locum a consultant, to work 24 hours on call covering both gynaecology and the labour ward. Normal staffing on the labour ward was a labour ward day consultant and a labour ward night consultant, plus a gynaecology consultant from 8.30am to 3pm. There should be the same level of cover every day. Yet on Christmas day a locum gynaecology specialist registrar was working with

a locum consultant, and on Boxing Day, a locum labour ward registrar was working with a locum consultant. The locum consultants were providing 24 hour cover. It is high risk to have a senior team to be composed of locums.

- There had not been a review of the number of medical staff against case mix and demographic change since 2017, despite the planned building of 43000 new homes in the borough by 2033.

Records

- **We observed some improvements in written records of patients' care and treatment, including contemporaneous notes. Records were now stored securely and available to all staff providing care.**
- During our last inspection we were concerned about adequate recording of key information and about confidentiality of records. We found on this inspection that paper now securely and plans were in place to improve ordering of patient notes. Full completion of notes was now part of all midwives' training and staff who now had access to examples of well completed notes and had to sign that they had reviewed these.
- There had been weekly audits of patient records since 17 December to check, for example, that records were recorded contemporaneously, and were signed and dated and there was patient ID on every page. There was a clear trend of improvement in response to staff focus on this area, so that compliance showed at 100% in January. However, it was too early to claim that improvements were embedded.
- National Antenatal Admission notes were used in the triage and MAU area for both antenatal and postnatal women (readmissions). Care in the postnatal ward was recorded in the intrapartum notes to ensure all inpatient notes were retained in the hospital. We reviewed a random sample of notes (only going back a few weeks and excluding antenatal notes). We found more comprehensive notes were now being written and staff recorded the reason if the records were not contemporaneous. CTGs were appropriately signed, dated and recorded. Fresh eyes checks were recorded. Senior staff said the improvement of records was work in progress. The initial focus was on CTG recording. We noted that triage notes were not fully completed. A weekly CTG review meeting aimed to disseminate learning to improve clinical outcomes.
- The trust's electronic Care Records System (CRS) was used for some obstetric information, for example VTE assessments. Another system contained ultrasound scan and blood results. Staff had received refresher training on using electronic records.
- On the previous inspection we had seen records left on tables in public areas and records without covers to preserve confidentiality of the contents. On this inspection we found records were stored in locked rooms and all records had covers.

Medicines

- **Staff did not always follow protocols when prescribing, and recording the administration of medicines.**
- The acting head of midwifery had identified that more work was needed to avoid medicine errors. In the past these had tended to be reviewed within pharmacy, with less focus on learning in maternity. There had been 70 medicine errors in the past year and the learning from these was now being reviewed.
- There had been three medicine incidents during the weekend before the inspection. Two concerned delay in administering medicine, in one case to a baby who should have received a medicine within four hours of birth. The other was a delay in treating three women who were waiting planned induction of labour because the medicine was not available. The last incident suggested poor stock control which we had noted in the September inspection on the antenatal ward.
- In reviewing postnatal notes, we found the timing of medicine was not recorded in three cases for one patient.
- On this inspection we found medical gases were secured and stored safely. There was a new Standard operating procedure for labelling of blood specimens and an audit programme to ensure compliance.

Incidents

- **The service had reviewed the processes for managing patient safety incidents, both serious incident requiring investigation and other incidents.** There was a new flow chart for serious incident investigation with checks, and a 10-day alert system for any investigations likely to breach the allotted time. 72-hour summary reports were established as the norm to highlight immediate learning. More incidents were being reported and staff were investigating incidents promptly and work had begun on sharing lessons with the wider service.
- At the previous inspection we found delays in investigating incidents, particularly serious incidents, and in identifying and disseminating learning.
- On this inspection, the acting head of midwifery said there had been an increase in incident reporting and more emphasis was placed on learning from incidents to improve staff understanding of incidents, and staff told us they now had more feedback about incidents across maternity.
- We saw information for staff about incidents and the process of investigation on noticeboards, including information about recently reported serious incidents and the importance of duty of candour. All incidents were now reviewed within 24 hours, except at the weekend when the review was on Monday. The number of open incidents was reducing and there were 23 open incidents at the time of the inspection out of 144 cases reviewed in the previous week. Incidents were reviewed by a multidisciplinary team (MDT) including a consultant. The meeting we observed was attended by a consultant and 12 midwives. A second meeting reviewed cases needing further investigation and/or external reporting. A practice educator attended the review meeting to identify points where further training was needed. We noted there did not appear to have been any preparation for case review meetings so the notes were not always in date order to consider the chronology of events, and during the meeting we observed a woman's birth plan was found to be missing from the envelope. Cumbersome notes and missing items had been the case at the previous inspection. However, we were told that changes were being made to notes' organisation to make sure the chronology was clear.
- Sharing of learning from incidents now took place in a meeting attended by staff at all levels from consultants to maternity assistants, as well as in a "Hot Topics" newsletter. Learning folders were kept for staff who could not attend the meeting. Trends in incidents and incident themes were highlighted to staff each month. Staff shortages and postpartum haemorrhage were the highest themes in the week before the inspection. The incident trends in December 2018 were in CTG, blood labelling, transfer from triage, needlestick injuries, wrong prescriptions and lack of administrative staff. Trends were displayed in graphical form to show their relative frequency. Learning was also shared at handovers and safety briefings.
- The service had reported seven incidents to the national Strategic Executive Information System (STEIS) since the previous inspection (September 2018). Before the acting head of midwifery took responsibility for the service in November 2018, it had not been routine practice to provide external 72-hour management reports of serious incidents. We were shown two examples of 72-hour reports of incidents that occurred in January 2019. These were appropriately completed and we were told that in future the governance team would prepare such a summary report as part of every serious incident investigation. Junior doctors were involved in SI reviews after training. Medical staff considered more time was needed for staff to learn from serious incidents. We saw that 25 more staff were to be trained in root cause analysis in March 2019.
- We saw that responses to serious incidents were now timely with appropriate investigation. For example, the central NHS failsafe system for new-born baby blood tests had triggered a concern which led to the discovery of 100 unopened emails in the postnatal ward and community midwifery had not been read. (The new-born blood spot screening programme helps identify several rare but serious diseases with a smallbloodsample, also called a heel pricktest). An immediate review established that only five babies had missed their blood spot screening in December 2018. An incidental finding from this incident was the discovery of a significant backlog of unread discharge emails. The service had responded immediately by setting up a subgroup both to establish how the service's failsafe for postnatal communication was breached and to identify actions required to develop a more robust process of discharging mother and baby from the hospital to community midwives.
- We were told there was no backlog of serious or other incidents. Some doctors did not feel learning from

incidents closed in the past few months had been disseminated fully to prevent recurrence. We were aware of the recurrence of some similar situations indicating that lessons had not been learned. For example, we noted that 10 women had been admitted to intensive care since mid-March 2018. Maternal ITU admissions were not reported on the maternity dashboard and the incidents had not been investigated as a group. There appeared to be no other way of escalating clusters of incidents for review.

- We formed the view that some senior medical staff were not treating governance as a priority. Junior doctors were not mandated to attend governance meetings. We were told that there would be a continuing audit of interventions made following serious incidents, to ensure learning was shared and embedded. It would only be possible to assess the effectiveness of this after several months.
- We noted that on the internal reporting system, the convention was to record intrauterine deaths as no harm, even when omission in care during the antenatal period may have been a patient safety factor. This classification did not reflect the psychological harm to a mother of losing a baby. We observed a case review where a woman appeared to have been offered no antenatal care between 15 and 33 weeks. The unexpected stillbirth may have reflected a process failure on the part of the named midwife for not ensuring the woman was followed-up. There is an opportunity to change classification on STEIS after investigation.
- The service was relaunching the growth assessment protocol (GAP) (recommended in Saving Babies Lives) to help improve the still-birth rate. We saw slides reminding staff to measure fundal height measurement from 16 weeks and plotting this from 26 weeks to identify intrauterine growth restricted babies (IUGR), small for gestational age babies (SGA) and very large babies, to ensure early surveillance, referral and intervention.
- We saw that despite recent efforts to ensure that resuscitaires were fully equipped, an issue in the warning notice, this was still a theme of incidents.

Safety thermometer

- **The service collected safety monitoring data and shared it with staff, patients and visitors. Managers used this to improve the service.**
- The hospital collected data and made returns for the national maternity safety thermometer. The postnatal ward displayed safety data on staffing, falls, pressure ulcers and MRSA using the safety cross system. There had been one case of MRSA in the previous month.

Are Maternity services well-led?

At our last inspection we were concerned about leadership and governance of the service for the following reasons:

- There was a lack of vision.
- The quality of data was inconsistent.
- Risk was not well managed and risk registers were not up to date.
- We were not confident senior leaders had sufficient oversight of the performance of the service, and that information was not being processed, challenged and acted on.
- There was inconsistent progress in the follow up of incidents and complaints and learning from these to improve the service.
- Patient records were not being maintained in line with professional standards and were not kept securely.
- Changes to processes were made without adequate governance.
- Junior staff had limited awareness of governance and were not being engaged in quality improvement.

During this follow up inspection we found:

- **The hospital had set up a subgroup to improve data quality and ensure there was a single data set for measuring maternity performance.** This work was at an early stage.
- **The trust was still at an early stage in engaging with service users to plan and manage appropriate services.** More progress had been made in engaging with staff.

Maternity

- **Although the hospital was making efforts to improve its maternity services by learning from when things went well and when they went wrong and to establish a learning culture, it was too early to judge success.**
- **Staff did not always follow protocols when prescribing, and recording the administration of medicines.**
- **Although the trust was reviewing its risk register and the process for agreeing risks for inclusion in the corporate and local risk registers, this was work in progress and would take time to embed.**

However:

- **There was a new leadership team in the hospital and in maternity, and a new trust wide divisional structure bringing more clinical experience into the division. Staff morale had improved.**
- **The hospital had a vision for what it wanted to achieve in improving key areas of safety and leadership with the involvement of staff** and there was and it would take time to ensure all the changes became embedded as routine.
- **Leaders were seeking through improved communication and training to promote a positive learning culture that supported and valued staff,** and move away from what staff perceived as a culture of blame in which they did not feel valued**.**
- **The service was adopting a systematic approach to improve the quality of its governance ensuring it was properly resourced. It was developing terms of reference for meetings to ensure objectives were clearly defined.** There were already improvements in managing serious incidents.
- **Governance and quality training had been included in mandatory training and staff were to be given a pocket guide.** A governance newsletter was now available to staff as well as slides showing learning from incidents.

Leadership

- **There was a new leadership team in the hospital and in maternity, and a new trust wide divisional structure bringing more clinical experience into the management structure to ensure the team had the right skills and abilities to run a service providing high-quality care.** Middle management was less well developed.
- At the last inspection the service lacked leadership and direction and senior staff had been unaware of weaknesses in some basic processes. Leaders were distant from staff and rarely present in clinical areas.
- The trust had made several senior staff changes since then. A new managing director had been in post just over three months, and a new director of nursing at the hospital had started about three weeks before our inspection. A new divisional manager with a clinical background had been appointed to lead the Women's and Children's Health Division. The managing director chaired a weekly Maternity Executive Oversight Group to oversee the improvement process. The trust Director of Midwifery, who has a trust wide role and meets with the Women's Clinical Board Monthly to discuss the maternity strategy on each hospital site, was acting as Head of Midwifery as a temporary measure to ensure safety and provide leadership.The clinical director had not changed.
- There had been organisational changes including in reporting structures so the HOM at each hospital site would in future report to the Director of Midwifery.
- The acting head of midwifery had experience of transforming services and change management and had considerable energy, drive and determination. The improvement plan was supported by Director of Improvement at Barts Health and support from NHS Improvement (NHSI). There were 'check and challenge' meetings with Newham CCG and with NHSI and NHS England.
- The acting head of midwifery was driving and monitoring the improvement plan daily and reporting weekly to the Oversight group. She was a visible and approachable leader who had earned the respect of staff and was involving them in developing solutions in an inclusive way. She worked from an office in the centre of the unit so was closely in touch with day-to-day activity. She was challenging quality and seeking sustainable solutions. The obstetric clinical lead was also proactive in supporting change. The acting head of midwifery was supported by two staff who had a

good understanding of the day to day issues and risk. There was less evidence of leadership from matrons or other area leads. Two of the matrons were recent appointments.

- We saw that the Board Quality Assurance Committee had received a verbal report on action plans to make improvements at the Newham Maternity Department.
- A leadership development programme was being developed to support staff at different levels in developing skills to question how activities were undertaken and the methods and processes used to achieve outcomes and, if necessary, to challenge them.
- There were sessional Professional Midwifery Advocatesto supportmidwivesin their clinical practice. There was no supervision to support the bereavement midwife.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve in improving key areas of safety and leadership with the involvement of staff.** There was a workable improvement plan with time-bound goals but it would take time to ensure all the changes were embedded as routine.
- At the last inspection staff had not been aware of the vision for the service and did not feel involved in developments and improvements. An NUH Maternity Unit Vision statement was developed by the MDT team in January 2019, to be followed by consultation with service users to find out their view on the vision statement. This would influence the development of the vision for the service. The draft statement was "Excellent care for women by staff who are respectful, compassionate and kind to each other" The final Vision statement would be ratified at the Women's Health Quality and Safety Meeting in February 2019.
- The maternity service aimed to be the place of birth of choice for the local community and was developing a realistic strategy to provide a safe and sustainable service, using CQC standards to drive improvements. The strategy would have built in checks to see how staff felt about the changes as well as progress to achieving the strategy. The improvement plan was framed in terms of actions to be completed but senior staff recognised the need to continue to monitor all areas to ensure they were fully embedded. Full transformation could take several years.

Culture

- **Leaders were seeking through improved communication and training to promote a positive learning culture that supported and valued staff,** and move away from what staff perceived as a culture of blame in which they did not feel valued**.**
- At the last inspection senior managers had limited awareness of staff morale. At this inspection senior staff recognised that there were some long-standing barriers to change. We found managers had provided opportunities for staff to express their views about the service and areas for improvement, and identify how to provide a better service to women.
- An anonymous sample survey of staff before the acting head of midwifery took over, had a 73% response rate. This showed that staff wanted more involvement in changing working practices and culture. The results included the findings that were few regular ward meetings or handovers, and 41% thought managers were not visible in their work area, some staff did not feel valued, 53% thought the culture was one of blame and there was a lack of communication.
- Almost all staff we spoke with on this inspection said there had been positive improvement since the change of management, and visible and proactive local leadership. Many welcomed the anticipated appointment of a senior governance lead, and the progress on the second theatre. Most staff were unaware that the new theatre arrangements were permanent. We noted that the second theatre remained on the risk register at the time of the inspection,
- The acting head of midwifery was encouraging open and honest discussions to encourage staff to voice both what worked well and what concerned them. Some of the issues identified were the need for staff to work together more collaboratively, the need for training in incident and complaint investigation, the need to streamline women's notes and the need to address some IT and estates issues. She was seeking to address concerns quickly. She aimed to develop individual

accountability among all staff and pride in their work, although recognised that this would take time to establish. Some doctors spoke of the need for a wider MDT culture change involving obstetricians, midwives, paediatricians and anaesthetists.

- There was also more emphasis now on sustaining staff well-being and developing supportive ways of working. Some of the physical changes to the environment such as air conditioning in rooms that used to overheat, new chairs in staff rooms and shoe lockers had helped.

Governance

- **The service was adopting a systematic approach to improve the quality of its governance, ensuring it was properly resourced, and was developing terms of reference for all governance meetings to ensure objectives were clearly defined. Governance and quality training had been included in mandatory training and staff were to be given a pocket guide.** A governance newsletter was now issued. There were already improvements in managing serious incidents.
- At the last inspection senior staff were aware of the need to improve governance at site level but were hampered by the loss of members of the governance team. There had not been a senior governance lead for some years. Work was in progress to make sure governance was underpinned by sound data.
- At this inspection we found there had been a review of the governance structure, which was in transition. The review, with involvement of staff and support from the governance lead for the trust, had identified a need for more clinical leadership. A new divisional director for Women's and Children's Health took up post in October 2018. Information about the divisional change was displayed on governance boards. There was a short presentation about the governance structure at the Tuesday risk meeting during our inspection. We were told staff were to be given a pocket guide on risk and governance and a regular governance newsletter would be issued.
- The terms of reference and membership of all governance meetings were under review and we saw draft versions dated November 2018. These appeared appropriate. Staff were required to have deputies who could attend if they were absent but members were expected to attend 75% of meetings. All meetings were required to be quorate and minute taken. The terms of reference for meetings showed the reporting structure within Newham hospital and within the wider trust within which the committee lay.
- The acting head of midwifery reported to the hospital managing director and the trust chief nurse. The clinical director and divisional manager reported to the divisional director who reported to the managing director for the Newham site. The managing director reported to the trust CEO. Staff who were aware of the governance changes were positive about them. Governance boards were seen in all areas displaying the maternity dashboard, the SI investigation process trends from incidents and learning in December 2018 and the new 2019 mandatory training programme**.** Awareness of the changes among junior doctors was low and some medical staff did not feel connected to governance issues. Medical engagement was something that longer serving staff said had declined over some five years.
- We were told senior staff were to have training in change management in January 2019.
- Leaders had put in place processes to manage performance issues in the service following the warning notice. Sub groups had been set up to look at the five key issues of concern: Data quality, Standards of documentation (midwives and doctors), Governance, Roles and responsibilities and Daily routines. Each subgroup had terms of reference and meetings were required to be quorate and recorded. Each provided a highlight report weekly summarising progress. We noted that some sub groups appeared not to have ongoing responsibility for ensuring their actions were embedded. For example, almost all the actions on roles and responsibilities were complete, but it was not clear whether they were producing the desired results. In a similar vein, we noted the infection control action log showed Completed/Near to Completion Actions as completed when audits showed there were still weaknesses, for example when the comments indicated "Clean stickers still not being applied to all equipment after cleaning". There was a risk that comments could be overlooked in the pressure to show action had been taken.

- The format of the monthly NUH Women's Health Quality and Safety committee meeting that took an overview of the service had been substantially revised. The draft terms of reference showed the remit of this group included reviewing progress of Serious Incident reviews and discussing shared leaning gained so far, reviewing all action plans to ensure timescales were adhered to and monitoring incidents reported on Datix and their frequency. There was a new standard agenda of items for discussion and standard reporting templates for the matrons to present information about their areas in a consistent way with graphical presentation to show progress month on month.
- There was now a trust-wide process to review and implement guidelines, starting six months before the guideline was due for review. The end to end process should take seven weeks.

Management of risk, issues and performance

- **The trust was reviewing its risk register and the process for agreeing risks for inclusion. This was work in progress and would take time to embed**
- At the previous inspection, we had found inaccuracies in the maternity dashboard and that there was weak awareness among doctors and midwives of all the risks in maternity.
- On this inspection we found the service was reviewing the governance framework including the identification of risk including through incidents and complaints. There was a maternity risk register. The five top risks were compliance with the CQC warning notice, aging ultrasound machine in fetal medicine, lack of capacity for obstetric scans, scanning machines and sonographers, storage of images from anomaly scans and the risk of inadequate management of pathological CTG tracings. We saw that considerable further work was taking place to improve CTG management.
- After the inspection the trust sent us a draft trust-wide NUH Women's Health Quality Governance and Risk Management Framework which was to be ratified at next NUH Site Quality & Safety Committee (in February 2019). This set out the principles, processes and strategic direction of Clinical Risk Management for Maternity Services and referenced the Risk Management and Serious Incident Framework (DH 2015) and "Managing Safety Incidents in NHS Screening Providers (PHE and NHS 2017). The aim was to create a culture where risk awareness, assessment, reporting, investigation of incidents and subsequent investigations were embedded and embraced, and where staff would be fully informed of trends, receive feedback and all be engaged in the required change and monitoring processes.
- On inspection staff told us a new local risk had been identified in discharge processes from the postnatal ward to the community. As a temporary measure until more robust arrangements were established, all women discharged were being telephoned 48 hours after discharge to check that a midwife had seen them. This was not on the January 2019 risk register. Staff had been informed of this through the new governance newsletter 'Spotlight on Women's Governance'.
- On this inspection, we found that the service now shared the maternity dashboard with all staff to improve awareness of performance. There was a near-final Standard Operating Procedure for the compilation and validation of the dashboard and a requirement for exception reports on items rated red or amber and a need to audit these items. The draft terms of reference of the Women's Health Quality and Safety Committee included review of the maternity dashboard.
- Some consultants we spoke with on this inspection were not aware of current service risks. We were not reassured that managers and doctors worked effectively together so that risks, learning and actions, were escalated through the structure, and were effectively being disseminated among medical staff. Consultants were not tailoring training to site specific local issues.
- We also had concerns about consultant cover. Ninety eight hours per week was the lower end of cover for a site of this size and complexity and we were concerned to see rota planning that allowed a senior team of locums over Christmas with locum consultants on call for 24 hours.
- We now saw prompt staff response to incidents, and trend reports which over time should improve safety.
- Senior staff were to have training on the importance of accountability and responsibility to emphasise that risk management was everyone's responsibility. The

Governance and Risk management framework was not yet embedded within normal practice. Leaders recognised there was more to do to embed a culture of shared learning from incidents and prompt action to help prevent re-occurrence, and that it would require sustained effort to embed and maintain high standards across the service.

Information management

- **The hospital had set up a subgroup to improve data quality and ensure there was a single data set for measuring maternity performance.** The hospital had recognised the issue although improvement work was still at an early stage.
- At the last inspection, we were not confident of the quality of some of the data and that information was being effectively processed, challenged and acted on.
- At this inspection, we found the hospital had set up a data quality sub group in November 2018 aimed to improve the integrity of data each month. This data would be used internally and shared externally, for example with the East London Health and Care Partnership and for Key Performance indicators. Staff were developing a Standard Operating Procedure for the governance of data change. An interim data quality manager was in post. Some staff had had refresher training on how to enter data on CRS and there were staff acting as IT champions to support staff with day to day issues.
- The trust aimed to have a common maternity IT strategy across all sites. Whipps Cross maternity service had already reduced reliance on paper. There were different electronic systems in use in the trust and staff were not yet clear what system would be used at Newham. We were told that a project had been set up to mirror the Whipps Cross model and move from paper to electronic systems by June 2019. We did not see the plan.
- The trust had a medium-term plan to use a more effective, efficient and user-friendly maternity IT system with a target date of November 2019.
- We again saw evidence that the IT infrastructure at the hospital was not robust. On one day of inspection sonographers were not able to report ultrasound results electronically because of an IT failure. Manual reporting led to delays in scanning women. Although we were told at the last inspection that community midwives would have laptops in the autumn, we found these had not been issued because the datadongleto connect the laptopsto the internet had not yet been obtained.
- There were improved arrangements to ensure external notifications to STEIS were timely and two incidents in January 2019 had been reported at the time of the inspection.

Engagement

- **The trust was at an early stage in engaging with service users to plan and manage appropriate services.** More progress had been made in engaging with staff.
- At the previous inspection we found staff considered communication to be top down rather than two-way and there was limited opportunity for open discussion.
- On this inspection, we found the hospital had held five staff engagement conversations with a range of staff. Further conversations were planned, including one specifically for junior doctors and for maternity support workers. The aim was to reflect the views of staff in developing the culture of the service. This would include the development of a Charter of Behaviour to be modelled by the senior maternity management team, and audited by the HR department.
- We found some indication that consultants did not welcome challenge and there were some areas of disagreement on safety issues and a lack of consistency of treatment. Staff mentioned some good medical staff appointed did not stay. Some consultants felt their voice was not heard at trust level.
- We had also found at the previous inspection, that the hospital had done limited work on seeking women's views of the service. On this inspection we found that as part of a trust wide exercise, the service had used a '100 voices' questionnaire "Women's views on the maternity service". 50 questionnaires were used for antenatal women and the same number for postnatal women. There were 42 responses from antenatal women and 32 postnatal responses. Recommendations for action were made based on the results that 16% of women reported

being left alone in labour at a time that worried them and that 10% of women said their concerns were not listened to. However, we did not see a report of progress in these areas.

- We also found improvements in response levels to Friends and Family test on the delivery suite, which displayed responses from December 2018 with quotations from women such as “The staff were welcoming and friendly”, “I had information about the progress of my labour”. There were also examples of changes in response to women’s feedback. For example, there was a daily system to make sure there were enough pillows, new chairs had been obtained so partners had a place to sit and there was prompt reporting of broken sinks. There had been an improvement in response rates on the delivery suite to 24% (December 2018).
- Feedback forms were collected in the antenatal clinic but as well as “Tell us what you think” there was a sign saying, “Staff feedback” which could be misleading to women. The trust sent us a print out after the inspection which indicated only seven responses in the antenatal clinic which was perhaps why feedback was not displayed in the clinic. We were not aware of arrangements to seek feedback from women who were primarily seen by community midwives.

Learning, continuous improvement and innovation

- **The hospital was making efforts to improve services by learning from when things went well and when they went wrong and to establish a learning culture.** There was greater dissemination of information to staff than at the previous inspection, and over time this should improve the service.
- The service was seeking to identify and share learning from incidents, including serious incidents, and from complaints using a range of different approaches. It was too early to evaluate the success of this.
- The bereavement midwife cooperated MBBRACE investigations. and monitored MBRRACE reports. She took part in child death overview panels and was involved in London and national bereavement meetings. She carried out an annual audit of stillbirths. The rate at Newham in 2017 was 5.3% which is just above the national average.
- The service did not seem to have capitalised on the benefits of learning from other maternity services within the trust through exchange of staff or site visits.

Outstanding practice and areas for improvement

Outstanding practice

- We observed outstanding energy and leadership from the acting head of midwifery.

Areas for improvement

Action the hospital SHOULD take to improve

- Continue to monitor all areas of the action plan, even when apparently complete to ensure new processes were fully embedded.