Royal Free London NHS Foundation Trust

Edgware Community Hospital

Inspection report

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Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	**Insufficient evidence to rate**
Are services well-led?	**Insufficient evidence to rate**

Our findings

Overall summary of services at Edgware Community Hospital

Insufficient evidence to rate

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Edgware Community Hospital.

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

The Edgware Birth Centre provides maternity services to the population Edgware. Out of area women and birthing people using the service included people coming from Northwick Park, Barnet, Harrow, Stanmore, and Watford.

Maternity services include a standalone birth centre. The birth centre is open 'on demand' for local women and birthing people presenting as low risk. Other services provided at the birth centre include antenatal appointments, antenatal education classes, and postnatal clinics. Between September 2022 and October 2023 ,19 babies were born at Edgware Birth Centre.

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

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We have not rated this location before. This service was registered with CQC 1 April 2010.

We also inspected two other maternity services run by Royal Free London NHS Foundation Trust. Our reports are here:

Barnet General Hospital - https://www.cqc.org.uk/location/RAL26

The Royal Free London - https://www.cqc.org.uk/location/RAL01

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection. We visited Edgware Birth Centre on 24 October 2023. We spoke with 10 midwives. We did not receive responses to our give feedback on care posters which were in place during the inspection.

We reviewed 5 patient care records, 5 observation and escalation charts and 5 medicines records.

Our findings

Following our onsite inspection, we spoke with senior leaders within the service and carried out two focused groups with midwives and more senior staff including medical staff, to explore pain management during labour. We also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Maternity

Good

Our rating of this service is good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- Staff assessed risks to woman and birthing people, acted on them and kept good care records. They managed medicines well.
- The service had enough midwifery staff to support women and birthing people who had booked to birth at the birth centre and two midwives attended all births.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of woman and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with woman and birthing people and the community to plan and manage services.
- Leaders operated effective governance systems and managed risks, issues, and performance well.

However:

- Although staff took immediate action to address the issue, it had not been recognised that there was a risk of abduction as the exit from the birthing centre was not secure.
- Although staff carried out daily safety checks of specialist equipment, records did not always correlate with the equipment in place and there was a lack of management oversight.
- There were issues with internet connectivity at the birth centre. However, this information was logged on the risk register.
- When required, staff were transferred to the main hospital site to maintain safe staffing levels in the obstetric led units in line with Ockenden recommendations. Therefore, people could not always access the service when they needed it due to several temporary suspensions.

Is the service safe?

Good

We rated it as good.

Maternity

Mandatory training

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

Midwifery staff received and kept up to date with their mandatory training. The service had a training guideline which included a maternity training needs analysis dated October 2023. This outlined all training requirement of all staff groups. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards. Health inequalities were identified in the training needs analysis and the service provided bespoke training relating to inequalities affecting their population.

The mandatory training was comprehensive and met the needs of woman and birthing people and staff. Mandatory training compliance was meeting the trust target of 90% with midwifery staff compliance at 95%. Training was divided into trust mandatory training and midwifery mandatory training. The midwifery mandatory training was delivered on five in-service study days and included professional obstetric multi-professional training (PROMPT), maternity mandatory update (MMU), infant feeding and safeguarding.

Training included cardiotocograph (CTG) competency; a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training. Staff completed training with partner organisations such as the local NHS ambulance service and better births on keeping births safe at home and improve outcomes.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed staff had completed both level 3 safeguarding adults and children. This was training delivered at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. The trust’s target for safeguarding training was 90%. Midwifery staff compliance with training was 100%.

Staff could give examples of how to protect woman and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked woman and birthing people about domestic abuse, and this was a mandatory requirement in the electronic records system. Where safeguarding concerns were identified, woman and birthing people had birth plans with input from the safeguarding team.

Maternity

The service had a safeguarding specialist midwife who visited the birth centre to support midwives. If a woman were to be found at high risk of needing safeguarding support or had social services involvement, they would not birth at Edgware Birth Centre.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns and were always available.

Cleanliness, infection control and hygiene

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

Maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. The domestic team carried out regular cleaning on the unit. The service generally performed well for cleanliness.

Staff followed infection control principles including the use of personal protective equipment. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month and compliance was 100%.

Records showed staff implemented recommendations following an infection control audit in June 2023 and were working in line with the national cleaning standard colour code.

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. We saw staff used ‘I am clean’ stickers to show equipment had been cleaned and was ready for use.

Staff cleaned birthing pools before and after use and carried out audits three times a week of the birthing pools.

Environment and equipment

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

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The Edgware Birth Centre was situated at Edgware Community Hospital. The service had two entrances and/or exits. The main entrance led to the car park, and another led directly into the Edgware Community Hospital and provided staff with easy access. However, the maternity unit was not always fully secure with a monitored exit system. We raised our concerns with leaders who took immediate action to maintain safety of women, birthing people, and their babies. Following our inspection, managers sent further evidence of an upgraded security exit system to assure themselves.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there were shared pool evacuation nets, a shared neonatal resuscitaire, resuscitation equipment for adults, and suctioning machines. There was a portable grab bag for emergencies and ‘born before arrival’ equipment bag.

Maternity

Staff carried out daily safety checks of specialist equipment including the resuscitaire and resuscitation trolley. The resuscitation trolley was new, and records showed staff carried out two separate checks: weekly and daily checks. However, these checks did not correlate, and we found two cannulas missing. We raised this with managers and the two items were immediately replaced. Managers informed us lessons were learnt and they would review their auditing system immediately to minimise risk and promote safety.

Electrical safety tests were carried out in May 2023 on electrical equipment to ensure they were safe for use.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

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

The Edgware Birth Centre operated a low-risk maternity service and certain aspects of maternity care were not available on site. The service excluded induction of labour, caesarean section, or any major surgical procedure. It also excluded inpatient care, transitional, and neonatal inpatient care. Following standard operating procedures, staff assessed women and birthing people to determine if they were suitable to birth at the birth centre. Only women and birthing people who met the criteria for safe care used the service.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. This included the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed five MEOWS records and found staff correctly completed them and had escalated concerns to senior staff where required. Audits for April and September 2023 scored 98%.

Staff completed risk assessments on women and pregnant people at booking which were reviewed at 36 weeks and at every appointment after, until they gave birth. Where there were potential risks, women and birthing people were required to use maternity services on the main hospital sites with birth centres and obstetric access.

Staff knew about and dealt with any specific risk issues. Any blood and screening results were available for staff to review through the trust's electronic patient record system. Staff tested for carbon monoxide (CO) monitoring as part of the 'Saving Babies Lives Care Bundle 2'. The service audited 10 women and birthing people's records for CO monitoring from April to September 2023. Data showed compliance at booking was 100% and at each antenatal appointment was 90%.

Women and birthing people who had been booked to birth at the service were alternatively provided with an 'on-call' phone number to use when they suspected they were in labour. The on-call midwife would then triage them over the phone and if suitable advised them to attend the birth centre. Midwives ensured the labour ward coordinator on the main hospital site was made aware of any booked intrapartum care to ensure they were prepared to provide additional support if required.

Women and birthing people who chose to birth outside of guidance had face-to-face meetings with a consultant midwife to discuss other birthing options. A joint appointment could also be arranged with a consultant obstetrician to discuss risks and other options available and to create a suitable birth plan together.

Maternity

Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh ears auscultation approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having regular fresh ears assessment. Records showed a partogram was commenced and completed hourly, on average this was commenced at the start of labour 90% of the time and completed hourly 100% of the time.

Despite this, the 'intrapartum fetal monitoring' policy had not been updated in line with national standards. We raised this with leaders and managers. Following our inspection, we were provided with an updated copy which was now in line with national standards.

Staff offered women and birthing people vitamin D supplementation and ensured they understood the importance of vitamin D. Women and birthing people were screened for mental health, domestic abuse, and child sexual exploitation. Staff used all this information to plan and provide safe care and to involve the right level of support and partner agencies required.

The service had clear guidelines for when staff should transfer a woman to consultant led care from midwifery care. Staff understood this guideline and told us when they had used it to ensure the safety of women, birthing people, and their babies.

Staff followed 'local safety standard for invasive procedures' (LOCSSIPS) safety checklist when using invasive procedures like suturing after childbirth. LOCSSIPS are designed to ensure staff followed safety barrier measures to minimise risks to patients.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Records showed staff used a situation, background, assessment, recommendation (SBAR) format to hand over care, for example, to the Barnet Hospital midwife. SBAR is a tool used to provide prompt and appropriate communication between wards and services.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff used the 'newborn early warning trigger and track' (NEWTT) national tools to assess and identify deterioration in newborn babies. We reviewed five NEWTT records and found staff correctly completed them and had escalated concerns to senior staff when required. NEWTT audits for April and September 2023 scored 100%.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Staffing

The service had enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment.

The service had enough midwifery staff to keep woman and birthing people and babies safe. Edgware Birth Centre was staffed by the Edgware continuity of care community team which consisted of four on-call midwives across the community. Women and birthing people who booked under Edgware community team received maternity continuity of care including antenatal, intrapartum, and postnatal care.

Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between March 2023 and August 2023 there were 26 red flags due to the temporary suspension of the service. However, this was in line with Ockenden recommendations to prioritise the obstetric led units.

Staff expressed concerns about the regular suspension of the service which created uncertainties for women and birthing people. Managers said they were working on increasing the profile of the birth centre and had started quality improvement (QI) projects to create awareness.

There was a supernumerary shift coordinator or bleep holder on duty round the clock based at the Barnet General Hospital who had oversight of the staffing, acuity, and capacity on each shift including Edgware Birth Centre.

Managers and leaders attended various meetings each day and discussed maternity staffing and acuity as part of their agenda.

Leaders completed a maternity safe staffing workforce review in line with national guidance in September 2023. This review recommended 378.43 whole-time equivalent (WTE) midwives Band 3 to 8 compared to the funded staffing of 378.61 WTE with a positive variance of 0.18 WTE staff.

The service had reducing vacancy rates, turnover rates, sickness rates and use of regular bank staff. Both staff vacancy and sickness rates across maternity sites was 6%.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. Records showed 100% of midwives had received an annual appraisal by September 2023.

Managers made sure staff received any specialist training for their role to progress in their career. For example, two midwives had received funding for specialist training and had completed a capital midwife ethnic minority fellowship programme. Majority of midwives were trained in newborn and infant physical examination (NIPE).

Records

Staff kept detailed records of woman and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could easily access records. The trust used a combination of paper and electronic records. We reviewed five care records and found records were clear and complete.

Managers informed us there had been issues with internet connectivity at the birth centre. This had been logged on both the service and trust risk registers to make senior staff aware of the issue and to ensure it was resolved.

Managers completed record keeping audits. From April to September 2023 compliance levels were between 80% to 100%.

Maternity

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Woman and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed five prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to woman and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and legible. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cupboards in the staff room and could only be accessed by authorised members of staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff learned from safety alerts and incidents to improve practice. Staff carried out medicine audits. Results of a medicines management inspection in July 2023 for Edgware Birth Centre and community midwifery scored 74%. Identified issues had immediate actions to minimise risks including purchase of a wristband printer. However, the service continued to experience limited access to Wi-Fi. These risks had been added to both the service and the trust risk registers.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed one incident reported in the 6 months before inspection and found it to be reported correctly.

The service had no 'never events' or serious incidents. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Maternity

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved woman and birthing people and their families in these investigations. Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent and gave woman and birthing people and families a full explanation when things went wrong. Governance reports included details of the involvement of woman and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were involved in improvement projects following incidents. For example, the 'mama academy' card. This was implemented to promote and support safe delivery of babies in partnership with the local NHS ambulance service.

Is the service well-led?

Good

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for woman and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them were shared with staff.

There was a clearly defined management and leadership structure in place. The maternity service was led by a group director of midwifery and supported by two heads of midwifery. The service at Edgware Birth Centre was managed by a consultant midwife and a community matron who had regular contact with the head of midwifery and the group director of midwifery.

The service was supported by maternity safety champions and non-executive directors. The chief nurse was one of the board maternity safety champions. Their role was to act as ambassadors for safety and enable communication from 'floor to board' (in other words from the wards up to the senior management and trust board of directors). They encourage staff to speak up and had created clear routes for staff to raise any concerns with the trust board.

Leaders were visible and approachable in the service for woman and birthing people and staff. Leaders had good oversight of the birth centre and were well respected. Staff told us they were well supported by their line managers, matrons, and a consultant midwife.

Staff felt supported to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Maternity

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for woman and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports, the East Kent report (Kirkup, 2023) when investing in their maternity strategy. Leaders involved staff, the maternity and neonatal voices partnership (MNVP) and women and birthing people in the development of the strategy. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The services maternity strategy set out six strategic priorities. One of their priorities was to work together with other local organisations to implement the 'start well' programme. Start well is a programme run by north and central London integrated care system, looking at how services can deliver the best care to meet the needs of local children, young people, pregnant women and people, and babies. Leaders knew of the impact the start well programme could have on how the service operate in future and were communicating with staff to ensure they achieve the best outcome possible for the birth centre.

As well as the maternity strategy the service had a maternity digital strategy and a peoples promise. The maternity strategy and the maternity digital strategy were both aligned with the trust's strategy. Due to the success of the maternity strategy the group director of midwifery had been approached to support the roll-out of similar projects across the trust.

Culture

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

There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place of work and spoke highly of the culture. Staff felt respected, supported, and valued. Staff told us improvements had been made to the culture and there had been changes to the management at Edgware Birth Centre and maternity leadership. Staff were positive about the department and its leadership team. They said the culture was of learning and improvement, and not of blame. Leaders were confident that staff would speak to them about difficult issues as there was an open culture at the service.

The service promoted equality and diversity in their daily work. The service had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement, and leaders were committed to create a positive culture of respect for all staff. Staff told us they worked in a fair and inclusive environment. They had opportunities to learn together and equal opportunity to progress in their career. Staff said they had not experienced any bullying or harassment while working at the service.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and staff were keen to tell us about this.

Leaders understood how health inequalities affected treatment and outcomes for woman and birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service referred to their local population as 'the global majority'. They recognised specific risk factors and poor outcomes experienced by women and birthing people from the global majority and had included this in their strategy. The service organised tailored parent education classes for Black woman and birthing people at the Edgware Birth Centre. They had plans to increase these tailored classes to other ethnic minority groups including Asian women and birthing people.

The service had an open culture where woman and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. Staff were updated with lessons learnt from complaints received in all maternity services cross site to prevent repeat occurrences. Lessons learnt from complaints were also shared with staff and the maternity and neonatal voices partnership (MNVP).

Patient and staff experiences were discussed as an agenda item at board meetings to ensure improvement plans were in place. The trust had a patient experience dashboard for maternity services. Leaders could use this dashboard to see information such as outcomes of family and friends survey, compliments and complaints and peer led conversations.

Leaders had good oversight of safety issues within the service. Leaders reported to the board at all bi-monthly board meetings. We reviewed the last 2 reports and found maternity was always an agenda item, with maternity issues and risks discussed.

The maternity department had several well-being initiatives captured on the trust's maternity peoples promise. This included quality improvement projects. civility and safety training, wellbeing days for art therapy and staff development opportunities including the capital midwife fellowship programme.

The service celebrated staff and team success. They recognised and rewarded staff through the 'maternity star award' scheme which were held quarterly to promote good practices. Staff also celebrated events such as international day of the midwife and international women's day.

Senior leadership team introduced a staff wellbeing round to build an interest in staff experiences and to gather their ideas for improvement. Maternity senior leadership team also delivered a maternity culture workshop for maternity matrons and clinical leads in May 2022. The workshop was to instil in leaders a nurturing culture in maternity and to connect better with their teams outside clinical settings.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff. Staff spoke positively about their governance process and felt it was effective.

Leaders held monthly clinical governance meetings. Following board meetings, senior leaders in maternity met and developed actions to improve on the service. Where improvements had been made, outcomes were recorded.

Staff accessed policies and procedures electronically when they needed them. Leaders monitored policy review dates and reviewed policies every 3 years to make sure they were up to date. Although all policies and guidelines we reviewed were in date, we noted information and references to the 'Intrapartum Fetal Monitoring' guideline was not consistent with national guidelines. We raised this with the leadership team, who were responsive and updated the policy to reflect current guidelines and best practice.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust developed an organisational structure to ensure that there were clear lines of accountability through which risks could be communicated and managed at the correct level. The service had an initiative-taking approach to anticipating and managing risks to people who used the service.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register in place. Risks were rated, and risk levels were scored using a red, amber, and green traffic light system. The birth centre risk register fed into the trust risk register for all risks identified. Risks were reviewed and monitored regularly and closed when resolved.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. The Maternity Incentive Scheme is a national programme that rewards NHS trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. In January 2023, the service provided sufficient evidence of their compliance on Saving babies lives version 2 against the clinical negligence scheme for trusts (CNST) required standard to the trust board.

Maternity

An Ockenden assurance visit in October 2022 included the Edgware Birth Centre. They assessed compliance with the 7 immediate and essential actions (IEA) from the interim Ockenden report. The team found that many aspects of the Ockenden recommendations were well embedded, including MDT working and training and fetal monitoring. The trust was commended on its recent progress, including their exit from the maternity safety support programme, as well as clinical outcomes and drop in perinatal mortality and morbidity rates. Managers and staff used all these results to improve woman and birthing people's outcomes.

There were plans to cope with unexpected events. Leaders developed a maternity 'single delivery plan' in response to the NHS England three-year delivery plan for maternity and neonatal services. The aim of the plan was to deliver change, prioritise actions and bring together learning and actions to improve maternity and neonatal care.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

The maternity service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Information was used to measure performance and drive improvement.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff password protected devices to ensure information was kept confidential.

Data or notifications were consistently submitted to external organisations as required. Leaders submitted data sets to the perinatal mortality review tool (PMRT), CNST and CQC.

Engagement

Leaders and staff actively and openly engaged with woman and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for woman and birthing people.

The maternity service established systems for engaging with internal and external stakeholders. The trust was an active partner in the Local Maternity and Neonatal System (LMNS), collaborating with other local maternity units to ensure personalised and safer care for women and birthing people.

Leaders worked with the local maternity and neonatal voices partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP were passionate about their role, they engagement with the service and recognised the difference they made to women and birthing people who accessed the service. The service valued their partnership working with the MNVP and engaged them regularly to ensure they were involved in service planning and delivery. The MNVP's had regular meetings with various staff teams at the trust and confirmed they had easy access to the senior leadership team to escalate any concerns promptly.

Maternity

The MNVP completed a ’15 steps’ peer review at the birth centre in June 2023. The MNVP report was positive, however they found the birth centre was under-utilised. There were few staff having any experience of the site and its uniqueness and how only a few women were told about its existence at booking. As a result, a quality improvement project was launched to increase the proportion of birthing people that were referred to the birth centre.

Leaders understood the needs of the local population. The maternity service collaborated with the MNVP to gather feedback, build interaction and relationship with hard-to-reach groups within the local community and bridge gaps in underserved communities by using social media platforms and community engagement initiatives.

The service always made available interpreting services for women and birthing people and collected data on ethnicity. The service had a language line and information was translated into the 10 most used languages in the local community. Staff used language cards for frequently used maternity words and actions that were translated into other languages to promote communication.

The service sought staff views to inform practice and patient care. Leaders engaged with staff through various staff meetings, forums, listening events, wellbeing rounds, Ockenden café drop-in sessions and newsletters. Local and senior managers were visible at the birth centre, they had walk rounds, which provided women, birthing people, and staff an opportunity to express their views and opinions.

The service produced and circulated several staff newsletters including, community staff newsletter and ‘risky business’ newsletter. The newsletters provided staff information on the support available including training and development and how staff could improve practice.

The service engaged with key organisations including partner NHS trusts, local integrated care boards, local authorities, and charities to improve women and birthing people outcomes.

Learning, continuous improvement and innovation

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

Leaders and staff were committed to continually learning and improving services. They had a good understanding of quality improvement (QI) methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. For example, the service was part of a UNICEF baby friendly initiative between August 2022 and July 2023. The results were positive.

The service was involved in various QI projects. This included birth reflection offered to women receiving postnatal care at the trust. Birth reflection and debrief provides women and birthing people an opportunity to talk through their birth experience and to enable them to have a better understanding of what happened during their labour and birth. The service also launched a place of birth choice QI project to raise awareness of the birth centre and to increase the number of people that birth there.

Maternity

The service carried out various audits at the birth centre. The results of the last three patient survey showed 100% compliance.

Leaders had developed a maternity 'single delivery plan' in response to the NHS England three-year delivery plan for maternity and neonatal services. The aim of the plan was to deliver change, prioritise actions and bring together learning and actions to improve maternity and neonatal care.

The service used a patient experience dashboard to analyse, monitor and assess information received from women and birthing people and their families to drive improvement in maternity services. The birth centre achieved 100% compliance in birth, labour and in post-natal care.

The service had innovative ways to learn and drive improvements. The service had a 'risk game' which staff played to learn from serious incidents or identified trends and prizes awarded for staff performance.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Maternity – Edgware Birth Centre

- The service should ensure references to policies and guidelines were up to date and in line with national guidelines.
- The service should ensure appropriate checks and oversight was maintained on safety and specialist equipment including resuscitaire and resuscitation trolley.
- The service should ensure internet connectivity at the birth centre improves to maintain safe management of medicines and records.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector and two midwifery specialist advisors. Carolyn Jenkinson oversaw the inspection team, Deputy Director of Secondary and Specialist Care.