Care Quality Commission

Royal Free London NHS Foundation Trust

The Royal Free Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at The Royal Free Hospital

Requires Improvement 

We carried out an unannounced (staff did not know we were coming), focused inspection of the Royal Free Hospital in response to concerns about maternity service. The concerns related to the maternity service's response in relation to a serious incident. Because this was a focused inspection our inspection activity focused only on parts of the safe and well led key questions. This means we did not look at all key lines of enquiry in each of the domains.

During our inspection we visited the combined antenatal and postnatal ward, the labour ward, birthing centre, triage, day assessment unit, fetal medicine unit and close observation maternal assessment. We spoke with 17 staff members including student nurses, band 6-8 midwifes, doctors and leadership team. We looked at three sets of notes.

Our rating of this service went down. We rated it as inadequate because:

- Systems and processes to manage safety incidents were not always reliable or effective. The service response following serious incidents was sometimes insufficient and not timely. Learning from incidents was not always effectively embedded.
- The service did not have patient safety information leaflets available in other languages which meant women who had a limited understanding of English were at higher risk of missing warning signs about their own and their babys' health. The service did not have readily available patient information explaining how to raise concerns or make a complaint.
- Staff without appropriate high dependency training looked after women that required enhanced care. The process of checking resuscitation trolleys was insufficient.
- The trust did not always formally apologise when things went wrong. There were no written records that families and patients received an apology which is not in line with the trust's policies and the statutory Duty of Candour. The Duty of Candour regulation sets specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The service did not have a clear vision and strategy. We were not assured the leaders understood and managed the priorities and challenges the service faced. We were not assured senior staff had a sufficient understanding of what the risks and issues were. The leaders and staff did not always display a good understanding of their population.
- The governance processes did not always enable the service to timely assess, monitor and improve the quality of care provided. The risk management approach was applied inconsistently. There was no robust and effective process to manage risks. There was poor accountability for ensuring the identified actions were implemented.
- The service was not always able to collect reliable data and analyse it due to issues with the electronic patient record system. The service had ongoing issues with computer connectivity to the WiFi network on the labour ward which meant notes could not always be recorded contemporaneously..

Following the inspection, we took immediate enforcement action as a result of our findings. We issued a Warning Notice, on the 13 November 2020, under Section 29A of the Health and Social Care Act 2008. We required the trust to make significant and immediate improvements in the quality of healthcare it provides.

Maternity

Inadequate ↓↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate because:

- We were not assured the service managed patient safety incidents adequately. Opportunities to learn and improve the service and prevent or minimise harm were missed as the initial investigation of causes was insufficient or too slow. The service could not provide assurance that the safety of service users was protected following serious safety incidents. The majority of serious incidents were referred for an external investigation therefore the service only completed an initial 72-hour review whilst awaiting the outcome of the external investigation. The 72-hour reviews were inadequate in identifying immediate actions therefore sharing of lessons learned was not timely. Learning from incidents was not always effectively embedded. For example, we asked staff if the service raised their awareness about hypovolaemic shock and some staff could not recall any specific training despite this information being covered in the latest risk newsletter.
- The maternity service did not have patient safety information leaflets available in any language other than English; for example, on reduced fetal movements or induction of labour. Exploring the possibility to develop leaflets in other languages was one of the suggestions following a serious incident that happened in February 2020. Senior staff confirmed that this did not happen. While some staff we spoke with told us the trust had such material, they were unable to locate it on the trust's intranet or within printed materials offered to women. This meant women who had a limited understanding of English were at risk of not knowing what to look out for in terms of fetal movements and what to do in the case of reduced fetal movements.
- Whilst staff kept detailed records of women's care and treatment and these were clear and stored securely, information was not always easily available and up-to-date. Systems to manage and share care records and information were not always reliable. For example, there were issues with computer connectivity to the WiFi network on the labour ward that meant occasionally staff were documenting observations on pieces of paper and adding it in retrospect on computers outside of the room.
- Whilst the design, maintenance and use of facilities, premises and equipment was mostly good we found that the process of checking resuscitation trolleys was insufficient. We found several issues with the resuscitation trolleys, despite them being checked daily, including expired medicine (sodium chloride) and equipment (perimortem caesarean section pack), and items left on the trolley that did not belong to it. When we requested, staff could not locate a perimortem caesarean section pack or a scalpel on the trolley located within the combined antenatal and postnatal ward. Therefore, we were not assured the appropriate equipment was available to staff when it was required
- In most areas the service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Senior staff told us the close observation maternal assessment (CLOMA) was staffed by band 6 or 7 midwives with high dependency unit (HDU) training. However, staff told us midwives without HDU training were allocated to CLOMA with variable support. This meant there were occasions staff without adequate training looked after women who required enhanced care. This was a risk to service user's safety.

However:

Maternity

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- They controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. The service kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. On review of three sets of patient notes we saw that deteriorating patients were managed well, and staff knew how to escalate.
- The trust revised their visiting and infection prevention guidelines to reintroduce access for partners during perinatal care. This was done to balance the needs of service users with the need to keep staff and service users safe and control the spread of coronavirus (COVID-19). The guidelines were reviewed and tailored to the local context. There was also special provision of compassionate visiting for women in vulnerable circumstances.

Is the service well-led?

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- The service did not have a clear vision or a robust strategy to achieve priorities and deliver high-quality sustainable care. We were not assured the leaders understood and managed the priorities and challenges the service faced. We heard discrepancies between what front line staff said and what senior staff told us was happening within the service. For example, whilst front line staff told us the service only provided telephone interpretation services the senior staff told us that face to face interpretation services was available. Senior staff gave us inconsistent answers regarding lessons learned following a serious incident. For example, we were told paper MEOWS (modified early obstetric warning score) were introduced due to difficulties in recognising deterioration on the electronic patient system. A senior staff told us this related to WiFi connectivity and was not related to staff's ability to recognise deterioration. This did not give us assurance senior staff understood what the issues were.
- The governance processes did not always enable the service to assess, monitor and improve the quality of care provided in a timely manner. The risk management approach was applied inconsistently, and the management of safety incidents was sometimes ineffective. Whilst some parts of the process were robust, such as reporting of an incident or referring incidents to a serious incident review panel, implementation and sharing of learning was not always timely. We saw an example of a seven month delay between a serious incident happening and sharing of learning with staff. Senior staff we spoke to were unable to give examples of when service-wide learning was implemented immediately after a serious incident occurred. We asked a senior leader about learning from the most recent serious incident involving a stillbirth which occurred a month before our inspection and they were unable to recall it.
- We were not assured senior staff had a good understanding of what the risks and issues were. We were given conflicting accounts in relation to why certain changes were implemented following a serious incident despite the incident being discussed during maternity risk meeting a month before our inspection visit. Following that incident, the service identified an issue with the electronic patient record system which was used across two trust hospitals. Mitigating measures were only implemented at the Royal Free Hospital and not the other site and senior staff could not explain why that was.
- The divisional risk register reflected staff concerns; however, processes to manage risk were not always effective. The service appeared to have a structure to manage risks and these were regularly reviewed and mentioned during maternity risk meetings, however, there was no robust and effective process to manage them. Five out of 13 risks were over three years old with three risks from 2014. Some control measures and mitigating actions were inadequate

and not timely. From the documents provided, we did not see senior staff seek timely assurance that actions to eliminate, reduce or control risks were effective. For example, following the introduction of mitigating measures related to VTE (venous thromboembolism) assessment, staff identified an audit was needed to assess compliance. At the time of the inspection, this was still an outstanding action on the risk register since January 2020. There was insufficient accountability for ensuring the identified actions were implemented. While the actions were assigned to individuals, it was unclear how staff were held to account since we saw several actions not being progressed for months, or not meeting the deadlines.

- The trust did not always formally apologise when things went wrong. The written communication with women and/or their families did not include an apology when it was appropriate. While senior staff told us they apologised when they met with the women and/or their families in person, there was no written record of it. This was not in line with the trust's Duty of Candour policy, Incident policy and the Duty of Candour regulations.
- The service was not always able to collect reliable data and analyse it due to issues with the electronic patient record system. This made it difficult for the service to understand and improve performance in areas where errors occurred. This had been a risk on the risk register since 2014.
- The service did not have readily available patient information explaining how to raise concerns or make a complaint. In the areas we visited we did not see any leaflets or posters explaining to the service users how to make a complaint should they wish to do so.
- The leaders and staff did not always display a good understanding of the needs and knowledge about their population. When asked about most widely spoken languages other than English amongst their service users, staff told us "Jewish", "Asian". When we asked about the proportion of non-English speakers, staff told us that around 40% of service users were from Black, Asian and Minority Ethnic groups.

However:

- Staff told us they felt respected, supported and valued. They were focused on the needs of patients receiving care. The service took some steps towards promoting equality and diversity in daily work and provided opportunities for career development. A consultant midwife led on implementing the NHS England Better Births vision, which focused on the continuity of care during the maternity journey, before, during and after the birth. The service specifically targeted two of the most deprived areas to offer women continuity of care with a view to improve their outcomes and address health inequalities.
- There was some engagement with patients, staff and equality groups to plan and manage services. Senior leaders told us there was good engagement with service users through the Maternity Voices Partnership.

Areas for improvement

We told the trust that it must take action to bring services into line with legal requirements. This action related to maternity service.

- The trust must ensure actions and lessons learned following a safety incident are implemented in a timely and effectively way. (Regulation 12)
- The trust must ensure effective monitoring of compliance following the implementation of recommendations and lessons learned. (Regulation 17)
- The trust must have patient safety information leaflets available in other languages. (Regulation 12)

Maternity

- The trust must ensure information explaining to patients how to raise concerns or make a complaint is easily available. (Regulation 16(2))
- The trust must have an effective mechanism to manage resuscitation trolleys. (Regulation 12)
- The trust must ensure it complies with the Duty of Candour regulations. (Regulation 20)
- The trust must ensure their governance arrangements have effective structures, processes and systems of accountability. (Regulation 17)
- The trust must ensure internal audit processes function well, are timely and have a positive impact on quality governance. (Regulation 17)
- The service must ensure electronic and paper patient record systems are suitable and reliable. (Regulation 17)

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, inspector and specialist adviser who is a consultant obstetrician. Due to the COVID-19 pandemic some interviews took place via video conferencing technology. Overall leadership was provided by Nicola Wise, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour