Royal Free London NHS Foundation Trust

The Royal Free Hospital

Inspection report

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Ratings

Overall rating for this service

Inspected but not rated

Our findings

Overall summary of services at The Royal Free Hospital

Inspected but not rated

We carried out this unannounced focused inspection of the maternity service to follow up on concerns we identified during our last visit in October 2020 when we rated the service overall as inadequate. Overall, during this inspection, we rated safe and well-led as 'requires improvement'. Effective, caring and responsive were not rated on this occasion and stayed as 'good'.

How we carried out the inspection

During our inspection we visited the combined antenatal and postnatal ward, the labour ward, birthing centre, triage, day assessment unit, fetal medicine unit, close observation maternal assessment (CLOMA) and antenatal clinics. We spoke with 23 staff members including student midwives and junior doctors, band 6-8 midwifes, consultants and leadership team. We looked at 15 sets of notes, attended morning handover, cross site huddle and governance meeting. Due to the COVID-19 restrictions some interviews took place via video conferencing technology.

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

Requires Improvement 

Our rating of this service improved. We rated it as requires improvement because:

- The service still had limited knowledge of their local population, including their cultural and social needs, circumstances and challenges they faced.
- There was limited work to understand and address health inequalities and improve outcomes for the most disadvantaged groups.
- The service did not always effectively engage with staff and service users to improve and develop their services.
- Although the service had improved their working relationship with the Maternity Voices Partnership (MVP) group, more work was needed to connect with women from diverse backgrounds and to utilise the group's expertise.
- During handover staff did not always include psychosocial assessments and information about women's emotional needs.
- Compliance with electronic prescribing and medication administration was low.
- The service did not carry out any pain relief audits including assessment of if women from different ethnical backgrounds received the same level of care.
- Although the service had a dedicated team of specialist infant feeding midwives, there was limited breastfeeding support out of hours and at weekends.
- Staff did not always discuss vitamin D with women which was not in line with national and trust guidance.
- Although the service recently appointed a non-executive director with the responsibility of maternity services, they were on long term leave and no replacement was arranged by the board.
- Managers did not always address ongoing issues with staff who failed to follow trust values. Lack of action to resolve certain issues resulted in staff ceasing to report them.
- The birth centre had a clinical look and lacked "homely feel" typically associated with birthing centres.

However:

- The service had improved IT systems; the trust employed IT midwives who trained and supported staff with any emerging issues. However, more work was needed as the infrastructure was sometimes unreliable which resulted in delayed clinics.
- Critical patient safety information was available and accessible in alternative languages across maternity clinical areas and the website.
- The service had good safeguarding processes and a dedicated team that looked after the most vulnerable women.
- Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.
- During handovers women were discussed using the SBAR technique (Situation, Background, Assessment, Recommendation) which is an effective method of communication between healthcare professionals.
- The service had a dedicated pharmacist who assisted with preparing TTA (take home medicines) packs, carried out audits, stock checking and stock ordering.

Maternity

- The service had improved the way they shared learning with staff. They used different forums and media to communicate changes in practice.
- Staff said they were encouraged and had opportunities to do additional courses. However, midwives who completed new-born and infant physical examination (NIPE) screening training did not have the opportunity to practice their skills.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

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 mandatory and statutory training (MAST) that was comprehensive and met the needs of women and staff. Staff were automatically allocated training places and the dates were added to their duty rota. Managers took action if staff missed training. Staff asking for any additional training had to be up to date with their MAST. Midwifery staff compliance with mandatory training was 88% which was below trust target of 90%. Junior doctors were at 63%.

The mandatory training included cardiotocography (CTG, which records the fetal heartbeat and the uterine contractions during pregnancy) and PROMPT (practical obstetrics multi-professional training). There was good compliance with the CTG training with 95% midwives and 91% doctors receiving the training. The CTG, PROMPT and safeguarding training were multidisciplinary (attended by both nursing and medical staff). In addition, CTG leads run regular CTG sessions on recognising Hypoxia, Chorioamnionitis or CTG using Dawes Redman criteria.

COVID-19 pandemic restrictions meant that most live emergency drills were suspended and happened online instead, but the service was planning to restart live drills – for example, for pool evacuation or baby abduction.

Safeguarding

Staff understood how to protect women 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.

Medical and midwifery staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm. The safeguarding training included an awareness of Child Sexual Exploitation (CSE), domestic violence (DV) and Female Genital Mutilation (FGM). Level three safeguarding training compliance rates were 85% for doctors and 95% for midwives.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They worked with other agencies to protect vulnerable adults and children. The service had a dedicated 'Unity' team, that provided perinatal and postnatal care to vulnerable women. The service had a clear pathway for women with FGM, or whose unborn baby girl might be at risk of FGM.

Maternity

Staff were aware of and offered additional support for women who did not meet the criteria for a safeguarding referral, but who needed additional support because, for example, they were having their first baby and had little or no support from family, or because English was not their first language and they had limited community support.

Due to COVID-19, numbers of face-to-face appointments were reduced. Staff recognised this as a risk. They appropriately screened women and ensured safeguarding questions, including questions about domestic abuse, were asked at the first direct contact with the woman. The trust audited compliance with the screening for domestic violence. Between December 2020 and May 2021, the compliance rates were between 90-100%, with most months showing 100% compliance.

If a woman missed her appointment staff would call her the same day to reschedule. For women who did not attend their antenatal appointments on three occasions a midwife would try to visit the woman at home.

We reviewed the latest version of the cross-trust abduction policy which was up to date and in line with national guidance. Due to the pandemic, the baby abduction drill was suspended. This was due to restart and a practice development midwife was awaiting approval.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Cleaning and hand hygiene audits between October 2020 and March 2021 showed compliance in most areas to be between 90% and 100%. There were no hospital acquired MRSA and C.diff infections between October 2020 and March 2021.

Between December 2020 and May 2021, the service reported no cases of surgical site infection and readmission of babies with infection. Readmission rates of women with infection within 30 days of delivery were low (0.58%). However, the service did not collect data on sepsis in the puerperium (sepsis developing after birth until 6 weeks postnatally). The trust's parameter was until 30 days which was not in line with the Royal College of Obstetricians and Gynaecologists guideline (*Green–top Guideline No. 64b, 2012*).

Environment and equipment

The service addressed some of the challenges with IT systems. 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 enough suitable equipment to help them to safely care for women and babies. Since our last visit the service had improved IT systems and equipment, although the work was still ongoing. Staff now had enough portable computer workstations to help them keep electronic patients records up to date. This was introduced together with IT support staff allocated to the department to troubleshoot any issues.

Many areas within the department did not have an air conditioning system. Staff said the room temperatures were unbearable during hot weather.

All equipment we reviewed had been serviced and was visibly clean. The service had improved how it checked resuscitation trolleys, with one person being given the task at the morning handover. Resuscitation trolleys were clutter free and all checks were fully documented daily, including medications and perimortem caesarean section pack.

The service had two operating theatres, located within a labour ward and close to the birthing centre, to enable staff to provide emergency care without delay. The neonatal unit was one floor above the maternity unit.

Staff disposed of clinical waste safely. They appropriately classified, segregated, stored, labelled and handed waste and clinical specimens.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. They knew about and dealt with any specific risk issues. We reviewed 15 patient notes which showed staff appropriately escalated women and babies to obstetricians and other specialists. In the records we reviewed, all women had a venous thromboembolism (VTE) risk assessment completed and were given VTE prophylaxis if indicated. An audit between December 2020 and February 2021 showed that all women had a risk assessment completed and documented at each antenatal appointment. Women were offered an induction of labour following 24 hours pre-labour spontaneous rupture of membranes which was in line with the NICE guideline [*CG190*]. Our review of records showed no delays in the induction of labour or transfer to a labour ward. When indicated staff followed a 'fresh eyes' approach to cardiotocography (CTG) interpretation for women who required continuous CTG monitoring. Any concerns were appropriately escalated. Staff completed a risk assessment at each antenatal appointment and documented it on the electronic patient records system (EPR).

Five weeks before the inspection the service reintroduced the electronic MEOWS chart (Modified Early Obstetric Warning Score) following improvement work and additional training. Compliance was regularly reviewed by senior staff with immediate feedback provided to staff if needed.

Staff completed risk assessments for each woman on admission, using a recognised tool, and reviewed this regularly, including after any incident. The audit data between March and May 2021 shows that women were reviewed within 30 minutes of arrival to triage or the day assessment unit.

While most live drills were suspended, the service continued with a neonatal life support (NLS) drill during the COVID-19 pandemic restrictions to ensure staff had up-to-date skills in resuscitation of the new-born infants.

Staff regularly audited Five Steps to Safer Surgery (a surgical safety checklist) which showed 100% compliance.

Since our last visit the service had made improvements to ensure critical patient safety information was translated to the top 10 languages spoken in the local community. These were available and accessible across all maternity areas and the website. Staff were aware of the leaflets and knew where and how to access them. Staff reported issues related to difficulties in accessing translation services through an incident reporting system.

Staff shared most of the key information to keep women safe when handing over their care to others, however, this did not always include psychosocial assessments and women's emotional needs. During handovers women were discussed

using the SBAR technique (Situation, Background, Assessment, Recommendation) which is an effective way of communication between healthcare professionals to prevent the use of assumptions, vagueness or reticence. The handover was concise, and staff were engaged. When possible, staff were allocated to women they were familiar with to ensure continuity of care.

Midwifery and Nursing Staffing

Most of the time, 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.

Although most of the time the service had enough nursing and midwifery staff to keep women and babies safe, managers regularly had to redeploy staff from other areas. Staff said the biggest challenge was vacancies and short-term sickness which had an impact on their workload, however, they said managers supported them by adjusting staffing levels according to needs. Any gaps in the rota were filled by bank and agency staff. In March and April 2021, the staffing fill rate was usually above 90%. Managers calculated and reviewed the number and grade of midwives using a nationally recognised tool. At the time of the inspection the midwife to birth ratio for the Royal Free Hospital was 1:25.3. The maternity services required a further 4.4 WTE (whole time equivalent) midwives to be 'birthrate plus' compliant. Birthrate Plus is a national tool available for calculating midwifery staffing levels. A further review of the midwife to birth ratio was due in September 2021. Staff ratio on the postnatal ward was 1:8. Some ward coordinators felt that due to workload they were not always supernumerary.

The service made improvements to ensure a midwife with HDU (high dependency unit) training was allocated to the close observation maternal assessment (CLOMA). Typically, one midwife was allocated to the CLOMA with additional midwife allocated if required. Staff said occasionally they were asked to cover breaks for labour ward staff, making it very challenging to care for women in both areas.

The birthing centre was covered by one midwife with support from the labour ward and the continuity of care (COC) midwife when they had a woman in labour.

The service had high vacancy rates for band 6 hospital nurses (21% in April 2021) and band 3 COC nursing staff (19% in April 2021). The service had a rolling recruitment programme, and a high number of midwives starting in September 2021.

Between October 2020 and April 2021, the staff turnover rate for most nursing staff in the hospital was 14%, however there were high turnover rates amongst band 6 nurses (25%) and for all grades amongst COC midwives (between 16% and 26%).

Medical staffing

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

The service had enough medical staff to keep women and babies safe. The service carried out an annual review to establish whether prospective consultant obstetric presence on the labour ward was in line with Safe Childbirth recommendations (*RCOG, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007*).

Maternity

The service had a twice-daily consultant led ward round. At weekends and bank holidays consultant rounds were held at 8am and 2pm and the service was looking at moving the second ward round to evening to be in line with recent recommendations. The service always had a consultant on call during evenings and weekends. The unit had consultant labour ward presence in line with the RCOG guidance. Junior staff felt supported and appropriately supervised. Medical staff attended morning handover which was multidisciplinary.

The staffing levels for obstetric anaesthetists and their assistants was in line with the Safer Childbirth recommendations. An anaesthetist was available immediately 24/7 with an additional anaesthetist allocated to labour ward for elective c-sections. A consultant anaesthetist provided cover for labour ward between 8am and 6pm weekdays. Out of hours cover was provided by the on-call consultant.

Associate physicians worked on the ward during weekdays to help with the service user flow. They prepared TTAs (to take away medicines), helped during the ward rounds and supported junior doctors by updating the electronic patient records (EPR) during ward rounds.

The service had low vacancy, turnover and sickness rates for medical staff.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely. However, there were known issues with the IT systems which at times delayed access to the records.

Women's notes were comprehensive. The service used an electronic patient records (EPR) system to store information but handheld information was kept in a folder by women. The service used the EPR system for baby records which were linked to the mother's records, making it easy to access.

Most of the time staff could access the relevant documents, however, there were known issues with computers and connectivity. At times, resolving the issues or finding a computer that worked delayed clinics. Staff said these issues occurred daily. They said they had a good support from the IT team who promptly responded to any problems they could not resolve themselves. Review of the risk register showed the issues with the IT infrastructure and connectivity was not recorded as a risk.

Following birth, parents were given a personal child health record (known as the "red book"). Red books are used nationally to track a baby's growth, vaccinations and development.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the service was still in the process of rolling out an electronic proscribing and medication administration system and compliance with this was low.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. A review of 11 sets of notes showed staff followed current national practice to check women had the correct medicines. They recorded all relevant information including allergies and weight.

Staff stored and managed medicines and prescribing documents in line with the trust's policy. The service had a dedicated pharmacist who assisted with preparing TTA packs, carried out audits, stock checking and stock ordering.

Maternity

In order to reduce prescribing errors and medication-related incidents the service introduced an electronic prescribing and medication administration system. However, compliance with the new system was very low. The IT midwife carried out frequent audits to check compliance and address any issues in a timely manner. The service had a target of 75% compliance of service user scanning at the point of medicines administration and 50% compliance of medication scanning at the point of medicines administration.

Incidents

The service improved the way they managed safety incidents. Most 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 women honest information and suitable support.

The service improved the way they shared learning with staff. They used different forums and media to communicate changes of practice as a result of an incident. For example, learning from incidents was shared during staff handover, team meetings, monthly maternity briefing calls, risky business newsletter or monthly risk meetings.

Staff knew what incidents to report and how to report them, however, they told us about some issues that they had stopped reporting due to lack of action from the management. For example, issues with staffing such as impoliteness, staff being uncooperative, poor staff attitude or feeling overwhelmed with work.

Staff received feedback from investigations of incidents, both internal and external to the service. We reviewed an external investigation report and saw that safety recommendations related to Cardiotocography training (CTG is used during pregnancy to monitor fetal heart rate and uterine contractions) and SBAR (SBAR is structured form of communication that enables information to be transferred accurately between individuals) were actioned. The service had one never event in the past 12 months. The incident was still being investigated, however, managers shared immediate learning with staff and implemented changes to prevent a similar incident from reoccurring. Staff we spoke with knew the learning from the incident and what action was taken.

Since the last visit the service had improved their duty of candour (DoC) processes. They had updated their DoC policy; managers recorded their initial conversation with women and families and sent an official letter that contained an apology where appropriate. When needed or requested by a woman or their family, staff used translator services to have a DoC conversation and to translate letters.

Managers debriefed and supported staff after any serious incident. Following an incident, a Professional Midwifery Advocate (PMA) facilitated a reflective conversation with the staff involved which followed the Restorative Clinical Supervision (RCS) approach. The aim of RCS is to have a positive impact on staff physical and emotional well-being. One of the PMAs was trained in mental health first aid and therefore had an enhanced understanding of mental health and the factors that can affect wellbeing.

Safety Thermometer

The service used maternity dashboard although the data was not always reliable.

Data collection for the Safety Thermometer had stopped. The introduction of a replacement data set was planned but had been temporarily paused due to the national response to COVID-19.

Although the trust produced an electronic maternity dashboard, the trust had identified that the data was not reliable. Data was currently being collated manually to populate the dashboard whilst work to correct the electronic dashboard was ongoing. The service reported limited information on their dashboard. They did not monitor certain metrics to

measure their performance, for example, there was no data on risk management, breastfeeding, smoking, staff sickness levels, the use of agency/bank staff, midwives to deliveries ratio, service user complaints, puerperal Sepsis amongst others. Also, consultant cover on labour ward was not RGA-rated (a system to indicate if a metric is within an expected range).

Is the service effective?

Inspected but not rated

We did not rate effective at this inspection. The previous rating of good remains.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. However, at handover meetings, staff did not always routinely refer to the psychological, emotional or social needs of women, their relatives and carers.

Some guidance and practices we reviewed were not in line with national guidance and evidence-based practice. For example, the trust's parameter for collecting data on sepsis in the puerperium was until 30 days which was not in line with the RCOG guideline (*RCOG, Green–top Guideline No. 64b, 2021*) which states the puerperal sepsis can develop after birth until 6 weeks postnatally.

If a woman with a low-risk pregnancy developed complications a named consultant was identified. For example, if gestational diabetes was diagnosed, the care of the woman was transferred to the obstetric consultant managing diabetes in pregnancy.

An audit between September 2020 and May 2021 showed 100% compliance with NICE clinical guideline [*CG 190*] that all women in established labour should receive one-to-one care.

The service had a lead obstetrician for perinatal mental health and women presenting with mental health conditions had access to a perinatal mental health team.

Staff said the service did not fully utilise the enhanced recovery pathway. Enhanced recovery is an evidence-based approach designed to help people recover more quickly from surgery, including caesarean section.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink. The trust had been awarded the UNICEF stage 3 Baby Friendly Award in recognition of the service's effort to enable mothers to make an informed choice about infant feeding and to support them in that choice. Although the service had a dedicated team of specialist infant feeding midwives, staff told

us women complained about limited breastfeeding support at night and in the community. The team was available Monday to Friday, with no weekend and evening cover. A survey of women's experience of maternity services from January 2021 showed that approximately 83% received active support and encouragement with feeding their baby, 12% women sometimes received support while approximately 4% reported receiving no support.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. They prescribed, administered and recorded pain relief accurately. However, the service did not carry out any audits in relation to pain, for example, if an epidural was given within 30 minutes, or if there were any differences in women from different ethnic backgrounds accessing pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. Managers and staff carried out a local programme of repeated audits to check improvement over time. Managers and staff used the results to change practice and to improve women's outcomes. The audits were presented at the monthly multidisciplinary clinical audit and governance meeting.

The current term neonatal admissions rate to neonatal units was in line with the 6% set by the operational delivery network. The service reviewed transfers from a home birth or a midwifery-led birthing centre to a labour ward. The unit had on average 6 transfers per month (10-12% of the total births). The main reason for the transfers was to give epidural anaesthesia. As of March 2021, the number of women booked for the continuity of care (COC) was 36% of all bookings and of these 47% were Black, Asian and minority ethnic women. Between January and April 2021 approximately 52% of women from the COC programme delivered baby with their named continuity of care midwife.

The service used the Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths. PMRT is a standardised approach that is utilised by maternity units and aims to support a systematic, multidisciplinary, high quality review of the circumstances and care leading up to each stillbirth and neonatal death.

Since the last inspection managers had improved how they shared information from the audits. All staff were invited to the monthly risk meeting where audit results were discussed. Review of the meeting minutes showed that between 30 and 45 staff members from different staff groups at different levels attended the meeting.

The service had high rates of emergency caesarean sections. While the trust benchmarked their outcomes, which showed the percentage was similar to other local trusts, there was no evidence the managers explored the reasons to understand the increased rate.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. However, some midwives did not have all the competencies needed for the labour ward; they were not familiar with the environment, did not have certain skills or lacked confidence in, for example, suturing or cannulating.

The clinical educators supported the learning and development needs of staff. The service had a maternity education team which comprised of a consultant midwife, a practice development midwife, a clinical teacher and a CTG midwife. The educational team agreed the content of the study days which incorporated changes to policies, NICE guidelines, or learning from risk meetings.

Managers supported staff to develop through constructive appraisal of their work. Trust data showed 93% of midwifery staff and 80%of medical staff had received an appraisal in the last year. Midwifery staff said they were encouraged and had opportunities to do additional courses, for example high dependency unit (HDU), leadership, suturing, new-born and infant physical examination (NIPE) or Professional Midwifery Advocate (PMA). Medical staff were positive about learning opportunities; they had regular study time slots throughout the week. Some of them were meant to be multidisciplinary such as CTG, human factor or case study reviews, however, midwifery staff could not always attend the sessions due to workload.

Daily new-born and infant physical examination (NIPE) screening was carried out by a neonatologist. There were no midwife-led clinics despite some midwives being NIPE trained. This meant that due to lack of practice their skills might dissipate and there was no multidisciplinary approach to the assessments.

Managers gave all new staff an induction tailored to their role before they started work. Staff were positive about their preceptorship programme (preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further). Staff said they were allocated a mentor but also received good support from their colleagues. A dedicated fetal monitoring lead midwife and lead obstetrician supported and developed staff with CTG interpretation and ran regular training sessions.

The service offered multiple joint clinics (with an obstetrician and the relevant consultant physician such as hepatologist, haematologist or endocrinologist) providing multidisciplinary care for women with complex medical needs including a joint hepatology, epilepsy, HIV, haemophilia, solid organ transplant, thyroid disease and diabetes in pregnancy.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Important messages such as changes to practice, new policies, and lessons learned were shared with staff through different forums to ensure all staff were included.

Most poor staff performance was identified by managers and these staff were supported to improve. There was a structured framework and improvement plan to support staff with their competencies and skills if these were not meeting the required standards.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. During weekdays the service held a daily cross-site (with another trust location) multidisciplinary (MDT) meeting which was attended by consultant midwives, consultant obstetricians, the on-call manager and neonatal team. During the meeting staff discussed admissions to the high dependency unity (HDU), staffing levels and any other operational issues that might affect the running of the service. Staff planned discharges at the start of a shift.

Twice daily MDT ward rounds included the consultant obstetrician, obstetric registrar, anaesthetist and labour ward co-coordinator. The service monitored compliance with this requirement. The data between December 2020 and April 2021 showed 100% compliance.

Staff worked across health care disciplines and with other agencies when required to care for women. We saw women and babies being appropriately referred to other specialities. The service offered several specialist clinics to support women, for example, a specialist diabetes clinic, a preterm clinic, and a complex needs clinic with support from a perinatal mental health team or a fetal medicine clinic. The trust worked with the local partners on developing a standard operating procedure that identified how women were referred into tertiary level maternal medicine centres.

Staff ensured safe discharge arrangements for people with complex needs. Midwives from the Unity team looked after women with complex social needs. They did ward rounds and discussed their care plans with the wider team. Women with complex health needs were referred to their GPs. Staff referred women for mental health assessments when they showed signs of mental ill health or low mood.

Seven-day services

Key services were available seven days a week to support timely care.

The service had consultant-led daily ward rounds on all wards including weekends. Continuity of care midwives were on call over a 24-hour period to support women and facilitate home births.

Staff could call for support from doctors and other disciplines, including mental health services provided by another trust and diagnostic tests, 24 hours a day, seven days a week. However, there was no breastfeeding support during weekends and evenings.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The Co2 monitoring had ceased due to the COVID-19 pandemic restrictions, however, staff continued to screen women for smoking. Women who smoked were offered smoking cessation referrals and were booked for serial scans. The service had a smoking cessation midwife. Women dependent on alcohol or drug misuse were referred to the Unity team. The service did not always discuss vitamin D with women which was not in line with recent recommendations and trust guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from women for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available. The service regularly audited compliance with consenting processes. For women who spoke limited English, staff used interpretation services. Staff clearly recorded consent in the woman's records.

Maternity

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles. However, there had been limited NED involvement.

The maternity services were led by a divisional clinical director, a director of operations and the director of midwifery and nursing who managed the services trust-wide. An interim lead for governance had the operational responsibility for overseeing risk management processes at divisional level. Locally, a head of midwifery and two clinical leads managed the maternity services. The head of midwifery had access to the trust board through bi-monthly maternity and neonatal champions meetings chaired by the trust's chief nurse. They reported good support by the board.

The Director of Midwifery was responsible for the women and children's service across both sites. They had implemented a Maternity Safety Improvement Plan to support the National Maternity Safety Ambition. Since our last inspection in October 2020, there have been many challenges which have included the Covid-19 pandemic, staff bereavements, implementing the CQC action plan, responding to the Ockenden review's seven immediate recommendations and more recently, a review of services was due to submit to the Clinical Negligence Scheme for Trusts (CNST).

The Women's and Children's divisional triumvirate was responsible for overseeing the Lead for Governance for Women and Children's services cross-site, they manged the women safety and risk manager and the compliance and audit manager and their various teams cross-site. Both worked along-side the care groups clinical director.

Trust maternity and neonatal champions monitored progress and improvement within the service. There was an effective trust board oversight of performance. The trust submitted the Ockenden assessment tool to NHSE/I regional team on 15 February 2021. Following the self-assessment, regional teams would assess the outputs of the self-assessment and would work with providers to understand where the gaps were and provide additional support where this was needed. The assessment took place between 22 February and 18 March 2021.

The Director of Midwifery confirmed that they had access to the trust board and felt supported. They were the local maternity safety champion and responsible for completing and reporting to the board the Ockenden Quarterly Serious Incident reports.

Three consultant midwives, one based at the Barnet Hospital site, one at the Royal Free site and the community and Birth centre consultant midwife worked cross site and monitored services across the care group.

Professional midwifery advocates (PMAs) offered leadership, advocacy and support to midwives through a continuous improvement process. They followed the A-Equip model which is a model that advocates education and quality improvement.

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The trust appointed a non-executive board level maternity safety champion; however, it was not possible to assess the effectiveness of this appointment as the role was not fully embedded and the person was on long-term leave. The trust board did not arrange a cover for the role.

Vision and strategy

The service had a vision for what it wanted to achieve however it was still unclear how they wanted to achieve it. While the vision focused on local community and personalised care not enough work was done to understand the needs and health inequalities of the local population.

The service had a draft vision for what it wanted to achieve. The vision and strategy were focused on providing family-centred services, community focus, and personalised care provided by high performing multidisciplinary teams. At the time of the inspection, there was no evidence the service made a detailed assessment to understand the needs and health inequalities of the local population. It was also not clear who was involved in designing the draft vision and strategy.

There was no gap analysis between current service provision and the vision set out by the service. Since the last visit, the service identified the most prevalent languages spoken by the women who use services, but no other work was done to understand the needs, circumstances and challenges faced by the service users and their families. While senior staff had developed a guideline on maternity care for women of Black, Asian and minority ethnic background, this was not widely known.

Governance

Leaders had improved governance processes and operated effective 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.

The service had made improvements to their governance processes since the last inspection at the trust in October 2020. Staff had developed a maternity risk management policy which identified key individuals, responsibilities, governance structures up to board level, and dissemination channels. The service also received greater support from the trust leadership team, including board members, to deliver this work. There was a better multidisciplinary approach to governance with all staff invited to attend the monthly governance risk meeting. The service introduced a rapid review template which clearly identified immediate actions taken by the service, although this was not always used for all serious incidents.

The trust planned to commission an independent review of trust quality governance processes. This was to strengthen governance arrangement with tighter processes, systems of accountability and effective structures embedded. However, records confirmed that this had not been completed at the time of inspection.

Leaders had made sure they formulated their own plan based on local services and we saw evidence that these were reviewed at the highest level. The trust's board meeting held on 24th February 2021 discussed the recommendations. The board minutes from that meeting stated: The trust had also been asked to undertake a maternity workforce gap analysis and set out plans to meet Birthrate plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report.

Leaders used data and incidents to review and update the risk register. The benchmarking exercise and some of the CQC actions were mentioned in the 20 care group risks currently identified on the risk register. Risks were reviewed monthly and planned actions monitored for effectiveness. Each risk had a score and any controls colour coded for their effectiveness.

There was a thorough process for reporting, monitoring and reviewing serious incidents. The Head of Quality Governance was responsible for reviewing policies, and serious incidents that had been presented to the Serious Incident Review Panel (SIRP). The medical director, consultant leads and trust quality team were responsible for monitoring the grading of incidents, implementing any immediate actions to reduce further risk and making sure that the duty of candour had been followed correctly and that families were kept informed of outcomes.

Consultants had a regular meeting where they discussed operational issues affecting their work, for example, job plans, absences, standard operating procedures, as well as women outcomes and complex cases. However, there was low attendance with six to 11 out of 20 consultants attending the last three meetings. While the meeting minutes were shared with those who did not attend, the minutes were brief and lacked detail to understand what was discussed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.

The board wanted to promote a culture of learning and continuous improvement to quality and outcomes from their services. There was a trust wide annual 'star award' for each care group. Maternity staff awards were led by the professional midwifery advocate, staff were encouraged to nominate colleagues who had gone above and beyond. The nominations were counted monthly and those staff who won were awarded a gift voucher. However, the most recent staff survey only received a 17% response. There were no current plans to increase staff awareness of the survey or give staff protected time to complete the survey. Poor response levels do not reflect the feelings of all staff working in the trust.

Staff were open and transparent throughout the care group. The consultant midwife had an open-door policy and staff told us they were approachable and supportive. Staff knew how to raise concerns about harassment and bullying, although nobody reported this as an issue during the inspection.

Staff knew how to report incidents and felt supported when they did this. Managers used incident outcomes to improve and embed new training. Staff we spoke to did not feel they were blamed when things went wrong.

Managers used several platforms to inform staff of the outcomes of serious incident investigations. Reports were uploaded to a secure network where all key staff had access and could read incident reports. The risk midwives produced a monthly risk business newsletter to inform staff of any current themes and trends. Staff were also sent email updates of changes to practice.

Midwives and doctors worked well together; we observed a culture of mutual respect in the way staff spoke with each other. Staff we spoke to felt the unit was friendly and open, and staff looked forward to coming to work most of the time.

The service had a freedom to speak up guardian and their contact details were clearly displayed in staff rooms and staff toilets. The contact details of the CQC and the trusts third party staff counselling service were clearly displayed.

Maternity

Most staff felt supported by their colleagues and managers. They said there was good teamwork and most staff worked as one team. They said, “Staff are amazing”, “Teamwork is great”, “Best groups of midwives and doctors ever”. Both doctors and nurses said they had good working relationships with each other. However, staff told us about a specific group of staff who often worked together and whom they found unhelpful, impolite and who would often overload more junior staff with work. Staff said this issue was known to the management, but the perception was that not much was done to address it. Staff reported low morale amongst continuity of care (COC) midwives which might reflect high turnover rates in that group of staff. Following the inspection, senior managers and the service leaders held a series of meetings with the community staff and agreed an action plan to address the low morale amongst the COC midwives.

Managing risks, 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.

Since the last inspection the service introduced the Maternity Services Risk Management Procedure guideline, which detailed the local arrangements for the management and reduction of risk within maternity services, clearly describing roles and responsibilities of staff. We saw evidence the guideline was presented at and discussed at the consultant and maternity risk meetings.

Senior staff improved how they managed risks, issues and performance and aimed to create a learning culture. Since the last inspection, the service had developed policies related to risk management, incident and near miss reporting and learning. Since January 2021 all staff were invited to maternity risk management meetings which were cross-site. Attendance at the meetings was good (between 30-45 staff members), with different staff groups at different levels joining the call. During the meeting staff discussed departmental risks, outcomes, updates to policies, audits, incidents and learnings among others. Also, the service invited all staff to monthly maternity safety briefing calls. These were organised a few times a month, at different times to ensure all staff could attend. The calls focused on mothers’ and babies’ safety, learnings from incidents, best practice and changes to practices. We saw examples of learning from incidents being timely shared with staff and discussed at different forums to reiterate the message and ensure it reached all staff.

Maternity dashboard data was discussed during the monthly risk meeting and if the service was found to be an outlier the data was compared to other local maternity units.

The leadership team and staff within the department knew what the top risks for the service were. We reviewed the latest risk register and found the risks matched most those that the staff we spoke with were concerned about. Whilst the service had a comprehensive IT improvement plan due to ongoing IT infrastructure issues, this was not listed on the risk register. The highest risk concerned the poor quality of data being collected from women for analysis. This and other risks had mitigating actions in place and were reviewed monthly at the maternity risk meeting.

The service had improved how they informed women and their families on how to make a complaint or provide feedback about their care. Posters on how to leave feedback were clearly displayed throughout the department.

Managing information

The service worked on improving the systems to collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. There was an ongoing improvement work of the information systems to ensure these were integrated and reliable.

The service had improved the way they manage information systems. Since the last inspection the service had employed IT midwives who helped with data quality and data cleansing. The IT midwives undertook data audits, training for staff, and empowered staff to troubleshoot basic IT issues themselves. Staff said that whilst at times the IT systems were still unreliable, they received very good and prompt support from the IT department.

The service had a systematic programme of clinical and operational audits to monitor quality, and processes to identify where action should be taken. Since December 2020 the service introduced the Maternity Comprehensive Audit, which was a monthly compliance audit on the use of Dawes Redman analysis (type of fetal heart monitoring), CTG, partogram (a labour monitoring tool), SBAR and monitoring of CTG interpretation through the use of 'fresh eyes' approach.

Since the last visit managers and staff had significantly improved the use of MEOWS (modified early obstetric warning score). Managers had a robust and comprehensive action plan that was frequently reviewed, there was clear communication with staff, localised training, frequent audits, and immediate action taken to address any issues. This work was overseen by the trust's Digital Board.

The service had improved the way they recorded women's communication needs by recording on the electronic patient record system languages spoken and additional communication needs.

Engagement

Leaders and staff did not always effectively engage with women and staff. Engagement was not a routine part of service development and improvement. Feedback was not always acted on.

Although managers gave us examples of when they engaged with women or staff, and processes were changed as a result of feedback, we heard example where engagement was not always followed through. Staff said women complained about not being treated the same as other women because of their ethnicity, however no learning was identified. Staff and women engagement were not strategically embedded into the service development and improvement plans.

While the service engaged with the Maternity Voices Partnership (MVP), trust staff felt that at times this work was done because there was a requirement to do so rather than the service genuinely trying to connect with and understand women and their families. Although there was an improvement in the working relationship between the MVP and the trust and we heard some good examples of collaboration work, this relationship was still developing. Sometimes the MVP were only involved in coproduction work once work was underway or already completed.

Some staff felt they were not actively engaged, and their views were not reflected in the planning and delivery of services. For example, there was limited engagement and consultation with staff on the continuity of care model adopted by the trust. Staff felt they were not listened to and their concerns were not addressed.

To increase the service user feedback response rates, the service's 'Your feedback matters' posters were visible in the clinical areas which demonstrated examples where women complimented the service, however there were no examples of how the service acted on complaints. Also, a number of public information boards had outdated information. For example, the antenatal clinic had information about the performance of the service from January to September 2020 and continuity of care from April to August 2020.

Each area of the service had an electronic device that women could use to provide feedback about their maternity care. Women could also use their phones or the trust website to access the survey. It contained around 30 questions including free text sections.

Maternity

Learning, continuous improvement and innovation

Most staff were committed to continually learning and improving services. They received a good support from a quality improvement team. However, the Maternity Voices Partnership (MVP) group was not fully utilised to improve outcomes for the service users.

The service did not fully utilise the MVP group as a resource to better understand the needs and improve experiences of the service users, especially from diverse and seldom-heard groups.

Staff had a plan to increase the number of women giving birth in the Royal Free birth centre. The centre had a clinical look and lacked a “homely feel” that birth centres typically offer. Staff tried to improve it with some decorative lights but there were no other features. To improve birthing numbers the service appointed a lead midwife for the birth centre whose role was to help promote the centre and improve the area.

Some staff said quality improvement (QI) projects were encouraged. There was training available to staff on QI methodology and support from the QI team if they had any improvement ideas. During the COVID-19 pandemic restrictions, QI projects were put on hold, however, staff were in the process of restarting them. In the next year the unit was planning to focus on four improvement projects: Induction of Labour, Better Births, Keeping Mothers and Babies Together, and Early Pregnancy. The projects were well and clearly set up with identified QI leads and a programme manager. However, senior staff acknowledged that although input from the ward midwifery staff was valuable, QI was not well embedded into the midwifery culture. It was identified that part of the problem was that midwives did not have dedicated time for QI projects, and the plan was to speak with matrons to bridge that gap.

The Royal Free Hospital had become a pilot site for postpartum haemorrhage (PPH is a heavy loss of blood from the genital tract within 24 hours of delivery) on accurately measuring blood loss.

As part of the 'Keeping mothers & babies together' initiative staff came up with the idea of providing knitted orange hats for more vulnerable babies. The orange that helps the team easily identify which babies need extra care; allowing them to take timely observations, blood sugar tests and extra support to establish feeding so that mothers and babies can stay together.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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:

- The service should ensure that midwifery staff have protected time to attend multidisciplinary training.
- The trust should consider strategically embedding staff and women engagement into the service development and improvement plans. The service should consider carrying our regular staff satisfaction and wellbeing surveys in order to regular measure changes in engagement and satisfaction levels, and be able to address any issues or concerns in a timely manner.

Maternity

- The trust should develop a standard operating procedure that identifies how women are referred into tertiary level maternal medicine centres. All policies and guidance need to be in line with the national guidance and evidence-based practice.
- The trust should consider their population's profile, health deprivation, disability and the broader needs of their culturally diverse communities when planning the service.
- The trust should make sure they initiate changes to services based on feedback received from women and implement the changes with the support of the MVP.
- The trust should ensure there is an active non-executive board-level maternity safety champion.
- The service should consider improving the maternity dashboard and regularly reviewed it against local and national standard to improve the outcomes. The service should carry out a regular and comprehensive audit related to pain relief.
- The service should improve midwifery staff involvement in Quality Improvement projects. The service should ensure the ward coordinators are always supernumerary.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.