North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at North Middlesex University Hospital

Requires Improvement 

Pages 1 and 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at The North Middlesex University Hospital.

We inspected the maternity service at North Middlesex University Hospital NHS Trust (NMUHT) 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 to help us understand what is working well to support learning and improvement at a local and national level.

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.

Our rating of this hospital stayed the same. We rated it as requires improvement because:

- Our ratings of the Maternity service did not change the ratings for the location overall. We rated safe as inadequate and well-led as inadequate and the overall rating for maternity services went down to inadequate.

How we carried out the inspection

We visited the Maternity Assessment Unit (Triage), Labour ward / Delivery Suite, the Antenatal, Postnatal Ward area which included Transitional Care, the Birth Centre, Labour Ward Theatre and the relevant Recovery area, Antenatal Clinic, and Bereavement room.

We spoke with 25 midwives and student midwives, we received information from a further 25 midwives, three support workers, five Doctors, five senior leaders, five women and birthing people and three birthing partners and or relatives during and following the inspection.

We received no responses to our give feedback on care posters which were in place during the inspection.

We reviewed eight patient care records, eight observation and escalation charts and 10 medicines records.

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

Inadequate 🔴 ↓↓

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

- Not all staff had training in key skills or how to recognise or report abuse. Staff did not aways manage safety well. Leaders did not always ensure staff were competent. Not all maternity staff had received an annual appraisal. We found varying levels of appraisal rates across the Maternity service ranging from 0% of staff having had an appraisal from the Magnolia team to 88% of other maternity staff having had an appraisal. The service did not always ensure equipment was maintained appropriately. Staff did not always assess risks to women and birthing people or act on them. The service did not always manage safety incidents well or support staff to learn lessons from them.
- Leaders did not always run services well or use reliable information systems. Staff were not always supported to develop their skills. Staff did not understand the service's vision and values, or how to apply them in their work. Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.

However:

- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse. Staff kept good care records and managed medicines well.
- Local leaders had the skills and abilities to run the service for women and birthing people and staff. Staff were clear about their roles and accountabilities. They were focused on the needs of women and birthing people receiving care.

Is the service safe?

Inadequate 🔴 ↓

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

Mandatory training

The service provided mandatory training in key skills, however, not all staff completed it.

The service provided training in midwifery skills. Maternity skills A which included a mentorship update, bereavement / saving lives care bundle and antenatal and new-born screening tests was 68% which was below 90% compliance rate.

Maternity skills B which included Female Genital Mutilation (FGM), concealed pregnancy, substance misuse, refugee and asylum seekers, mental health training compliance was at 76% which was below the service compliance rate.

The service reported an overall compliance of 77% for basic life support training (BLS), which included maternal life support training. This was below the services own compliance rate.

The maternity training needs analysis document of compulsory training needs expired April 2023; however, we were not aware if this was in the process of being reviewed.

Maternity

The service reported a training compliance of 63% in April 2023 for the Growth Assessment Protocol (GAP) training, this had reduced from 74% in January 2023. The service described this was an expected occurrence due to the Obstetric medical rotation. This meant leaders could not be assured that all staff were working in accordance with the GAP protocol and identifying, growth restricted babies in a timely way.

Staff were not up to date with their mandatory training. The service provided two sets of training figures those held locally and then also reported to the North Central London (NCL) Integrated Care Systems Local Maternity Services (LMS).

We found inconsistencies within internal and external data and having identified these differences within the data we recognised the trust could not be assured by the quality of data provided. Service data showed the overall Practical Obstetric Multi-Professional Training (PROMPT) which included neonatal life support compliance rate was 90%. This was broken down as 83% for doctors; 86% for midwives; doctors (band two - four) 89%; specialist registrar doctors 93%; and obstetric anaesthetist at 85% compliant. This was different to the training compliance data reported to NCL which were 96% for registered midwives; maternity support staff was 92%; consultant obstetricians were 94%; all other speciality doctors were 83%; and anaesthetic staff at 85%. This was a continued breach from our previous inspection in September 2021.

The services training compliance fetal monitoring cardiotocography (CTG) showed midwifery staff compliance was 90%, and consultants were at 100%. All other obstetric medical staff were reported below the service compliance level of 90% at 75%. This again was different to the data reported to the NCL which showed midwives at 94% and consultants at 83%.

Following a stillbirth, the Healthcare Safety Investigation Branch (HSIB) investigation reported safety recommendations “the Trust to enable clinicians to have the required knowledge and skills to be able to conduct a water birth in line with local and national guidance” November 2022. The service and staff told us that pool emergency evacuation training had been ceased during COVID-19 and at the time of the inspection had not recommenced. This meant leaders could not be assured staff were appropriately trained and competent to undertake pool evacuation in an emergency. Staff told us they continued to facilitate waterbirths without being appropriately trained which could put women and birthing people at the potential risk of harm.

Evidence provided showed the overall departmental compliance for medicine management was 93%.

The service had a lead midwife for education and workforce, who was supported by three practice development midwives (PDM). One of the PDM’s monitored attendance of mandatory training. We were consistently told managers did not always give staff time away from clinical duties to complete training because of staffing pressures, and study days being cancelled. However, during the factual accuracy process the service reported there were difficulties in achieving and maintaining the 90% requirement in mandatory training due to vacancies, staff shortages, sickness rates and strikes which meant staff were not always able to attend study days as planned meaning non-compliance in some staff groups.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked with other agencies to do so. However, medical staff did not always have training on how to recognise and report abuse.

Most staff received training specific for their role on how to recognise and report abuse, however, training records showed that not all medical staff had completed both safeguarding adults and safeguarding children training at the

required level for their role as set out in the service's policy and in the intercollegiate guidelines (2018 and 2019). The service policy stated medical staff were required to have safeguarding adults and children's level three training, but records showed 78% of medical staff had received safeguarding training level two. This was not in line with the services own policy or with the intercollegiate guidance. Compliance for midwifery staff completing safeguarding level three training was 91% which was above the compliance target of 90%.

The service told us that safeguarding training compliance for support staff and unregistered nursing staff within the maternity service was included in their induction training at level two training for all staff. We requested the latest figures for training for all staff working in maternity and we could not see evidence of refresher training for non-clinical staff at level two, therefore we could not be assured of the training compliance for these staff.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics. During handover we saw staff make reasonable adjustments to meet the needs of women and birthing people such as those living with mental health conditions.

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 women and birthing people about domestic abuse, and this was a field in the electronic patient records (EPR) system and paper records. We saw this recorded in records we reviewed.

Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. Staff had training in how to recognise and support women and birthing people in the event of a disclosure of Female Genital Mutilation (FGM) during the antenatal period. This included the reporting requirement and ensuring the pregnant woman or birthing person was referred to a specialist FGM clinic if required.

The service had a safeguarding team to support staff as and when needed. Women and birthing people's care records detailed where safeguarding concerns had been escalated in line with local procedures.

We found skills and drills training included baby abduction and had been included in the obstetric emergency drills programme. The baby abduction policy had expired in July 2021, evidence was not provided to show this had been reviewed. Staff told us that any babies considered "high risk" were tagged, however service reports identified that a "few" of the baby tags were not available, and that the maternity unit had a shortage of tags. Evidence provided reported the baby tagging system was an "unreliable tagging system and potential risk of system failure." We saw no evidence that action had been taken to improve the current "tagging" system to address these concerns. During the factual accuracy process the service told us that a security guard was present at the door 24 hours a day, seven days a week, there were access-controlled doors to prevent unauthorised exit from the ward.

The service had a named midwife for safeguarding was supported by the trust wide safeguarding team who had specific roles to support women and pregnant people who may have additional needs or benefit from reasonable adjustments, for those with Learning Disabilities, Mental Health needs including mental capacity assessments and deprivation of liberty safeguards (DoL's).

Maternity

The service told us they had several complex cases which included trafficking, homelessness, late presentation, non-engagement, and risks associated with a transient population. The service engaged regularly with social care colleagues to discuss complex cases or those needing additional review. The named midwife for safeguarding told us that they reported to the associate director for safeguarding.

Included within the safeguarding policies were actions for staff to take when a safeguarding allegation was made against them. However, during the inspection staff we spoke with were not aware of this procedure.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect women, and birthing people, themselves, and others from infection. In the wards and clinical areas, most equipment, and the premises were visibly clean.

Maternity services areas were clean and had suitable furnishings which were clean and well maintained. The areas we visited were visibly clean except for one worn and damaged chair on labour ward which was removed. Cleaning records were kept up-to-date and staff could demonstrate all areas were cleaned regularly.

Curtains around beds were disposable with dates of when they were last changed displayed. Domestics were on the wards every day and the environment appeared clean. We saw cleaning schedules in place and check lists which were all completed, dated, and signed. Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. We saw that equipment in the areas we visited was labelled with the date of cleaning and dates were current.

The service hand hygiene audit between February 2023 and April 2023 which showed 100% compliance. Infection Prevention and Control (IPC) audits identified 100% compliance between February 2023 and April 2023. However, divisional IPC exception reports for March and April 2023 showed environmental audits were between 92% and 95% which were below the service target of 98% compliance. Actions plans showed there were management “walk arounds” with ongoing timescales, however, there was a lack of specific and measurable targets.

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.

The service had one side room in the maternity ward which had a lobby area, which could be used to implement infection control precautions in the event of an outbreak.

Environment and equipment

The service did not always have enough equipment to ensure safe care and treatment. However, the design, facilities and premises were appropriate to keep people safe. Staff managed clinical waste well.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. We observed that there was a dedicated security guard at the ward entrance each day from 8am – 8pm who logged each person on entry and exit from the ward. We saw how they ensured the double doors were operated so that only one was open at a time and people were let in individually to prevent tail gating and unauthorised visitors.

Maternity

There was good compliance with emergency equipment checks. Records showed that the resuscitation trolley on labour ward was checked every day. The inspection team found equipment was stored safely. The lists of contents for the Post-Partum Haemorrhage (PPH) trolley and eclampsia trolley were in the boxes to show when they were last reviewed.

The service did not always have enough suitable equipment to safely care for women and birthing people and babies. Dawes Redman cardiotocograph machines are used to monitor a baby's heart rate and a woman or birthing person's contractions during pregnancy. We found there was a lack of Dawes Redman specific cardiotocograph (CTG) machines. We raised this with leaders during the inspection and received assurance that additional CTG machines equipped with Dawes Redman monitoring had been ordered.

The service had a centralised cardiotocography (CTG) monitoring system, however staff reported, and evidence supplied as part of this inspection identified it was ineffective and not fit for purpose. We were not assured action had been taken to understand the challenges with the system and any attempt to try to improve it.

Staff carried out daily checks on emergency equipment. Resuscitaire checks were completed within the labour room checklists and there were no gaps. Audits confirmed that staff consistently checked the resuscitaires. There was one resuscitaire for both maternity triage and the birthing centre. However, we found it was stood unplugged without the gases turned on. We also found when the birthing centre was closed the resuscitaire was not always checked. The service told us that it was a rare occurrence for this shared resuscitaire equipment to be used as "the birthing centre was for low-risk women, pregnant people" however we have seen evidence that this equipment is and has been used including cases that have been referred to Healthcare Safety Investigation Branch (HSIB) because babies required specialist treatment and care following births in triage.

Following our inspection, the service gave immediate assurances that this equipment would be in working order in accordance with the resuscitation council's recommendation of commencing resuscitation in under 60 seconds; however, having reviewed the evidence concerns remain regarding the accessibility and timeliness of being able to actively use this resuscitaire in an emergency due to its storage position and status.

The maternity ward had a breastmilk fridge in a dedicated room with access to a hand wash basin. All milk in the fridge was correctly labelled and dated. During the inspection, we found the baby milk fridge on the postnatal ward unlocked and there was no control over who could access the room. During the factual accuracy process the service informed us there was a security guard present at all times and access-controlled doors to the ward. In addition, the service informed us milk boxes which could be locked to ensure milk was safe from tampering were available. We did not see these in use during the inspection.

The fridge temperature had been recorded outside of range without staff recognising the fridge was faulty. This was escalated to staff; however, we found the fridge remained in use throughout the day containing bottles of opened formula milk. This was escalated again to the ward manager then the fridge was taken out of service.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. Pool guidelines were not available as they were under review.

The service had bereavement facilities in the event of fetal loss. This room was soundproofed and had adequate facilities to meet the needs of families. However, to reach this designated room the woman, birthing person and family had to attend the main labour ward door and walk through labour ward to the bereavement room. This was not in line with the national bereavement pathway recommendations and the Stillbirth and Neonatal Death Support's (SANDS) position statement. During the inspection staff told us of an incident where the cooling fridge in the bereavement suite

had not had daily checks for several days which resulted in deterioration of fetal remains. We reviewed the National Reporting and Learning Systems (NRLS) for the 12 months prior to our inspection and did not find any reports of this incident. During the factual accuracy process the service informed us of an incident reported in 2022, however, this was not the case. Following a further review of NRLS we found the incident occurred in early 2023.

Rooms on the labour ward were designed and equipped for labour, delivery, recovery, and postnatal care. Women and birthing people could reach call bells and staff mostly responded quickly when called, we saw staff answer call bells on the maternity ward and labour ward.

The service had completed a ligature risk assessment and staff told us any risks to vulnerable people would be mitigated by 'cohorting' with a birth partner or member of staff.

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

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 did not always complete and update risk assessments for each woman, birthing person or take action to remove or minimise risks. We were not assured that staff always identified and quickly acted upon women at risk of deterioration.

Leaders did not monitor patient waiting times in maternity triage, which meant they could not be assured that women and birthing people accessed services when needed and received treatment within agreed timeframes.

We found no evidence of a risk assessment tool being utilised in the triage area. We reviewed triage records and found that the women and birthing people's presenting condition had not been risk assessed on arrival. This meant we were not assured there were effective systems and processes in place for managing and responding to patient risk within the triage area of the service. In addition, we found pain assessments were not completed during the triage process, despite one person communicating they were in pain.

The service reported they used an evidence-based, standardised risk assessment tool for maternity triage. We saw posters on display about the specific assessment tool, but staff told us they were not using this, and they didn't have service guidance to follow.

There was no dedicated midwife allocated to take triage telephone calls. The telephone triage line was answered initially by a ward clerk, there was an informal process in place in which the ward clerk would direct these calls on to a midwife within the triage service. We observed the midwife delivering care would be interrupted to respond to these calls. There was no clear process to record triage calls to allow the monitoring of repeat callers or non-attendance. There was a lack of guidance for staff to follow in the triage area.

The service provided evidence which showed the lack of triage and risk assessment process had been identified in August 2022. We did not see any action had been taken to address this. We saw evidence of high-risk women and birthing people receiving intrapartum care in triage despite care plans identifying them as needing care on a delivery labour ward.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed eight MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. A quarterly audit report of 30 MEOWS records showed that records were fully completed and escalated appropriately. However, the audit information was incomplete and showed there was low compliance on some elements of the audit, which meant managers could not be assured MEOWS was being effectively used and escalated.

The service informed us MEOWS was used in all areas, however, evidence provided showed MEOWS was not used in Maternity Day Unit or Triage and was only used when women attended for blood pressure monitoring. The MEOWS audit reported “all women attending via triage have the BSOTS form completed which includes MEOWS chart”. This was contrary to our observations and findings during the inspection as the service was not using a risk assessment tool in triage.

The service provided a fresh eyes audit between August to December 2022 and showed there was good compliance with fresh eyes including sticker use, date, and time recorded. An action plan which accompanied the audit ensured continued compliance.

We observed staff handovers included all necessary key information to keep women and birthing people and babies safe. Handovers used a structured Situation, Background, Assessment, Recommendation (SBAR) format. However, staff told us SBARs were not always used. We asked for but the service was unable to provide an SBAR audit.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aimed to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists between January and April 2023. Over the 4-month period 3% did not have methicillin resistant staphylococcus aureus (MRSA) screening documented. An action plan was created to be used to reduce occurrence.

There were two safety huddles per shift to ensure all staff were up to date with key information.

We saw and staff told us they completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

The service had a specialist midwifery team to support women and birthing people experiencing mental health problems during pregnancy and up to one year after giving birth. The team ran activities that supported clients to focus on mindfulness and physical wellbeing.

Communication and understanding are important in all healthcare settings. interpretation and translation should be provided free at the point of delivery, be of a high quality, accessible and responsive to a patient’s linguistic needs (NHS England, 2018).

Maternity

The Royal College of Obstetricians and Gynaecologists (2008) (RCOG) recommends that interpreting services should be provided for women and birthing people where English is not their first language. Where interpreting services cannot be pre-arranged, or outside normal working hours, telephone interpreting services should be used.

We saw evidence that women, birthing people, and babies had come to harm as a result of the service not using the recognised standard of interpretation services as set out by NHS England. Following a stillborn baby the Healthcare Safety Investigation Branch (HSIB) had made safety recommendations to the service (February 2023) “the trust to ensure that staff use the local and national guidance in respect of interpreting services and translation, to allow mothers to have access to the information that they require during their pregnancy”.

Staff had access to interpretation services 24 hours a day, via telephone interpretation service, three face to face Turkish translators and at times other face to face translators could be requested. However, staff told us it could be difficult to speak to an interpreter with the correct language and dialect and at times family members were used for translation, this is not in line with national guidance. Staff told us that interpretation services were under the risk register. Staff told us that British Sign Language (BSL) interpretation booking system was fragmented and was not always effective.

We saw leaflets and posters in English, and one leaflet for reduced fetal movements translated had been seen. The Ockenden Assurance visit report August 2022 reported that the service had recognised translation as a key risk for the service, however there was a lack of translated leaflets and information on how women and birthing people can access translation / interpretations services. Ockenden review August 2022 also reported that there wasn’t obvious communication on how translation / interpretations service could be accessed.

The service told us that they had provided translation services 185.6 hours between January and May 2023 which equated to an average of 11 hours per week over this 17-week period.

The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) data for the service flagged the service in the red category, indicating that this service was more than 5% higher than the average group.

All NHS maternity services are working to "Saving Babies’ Lives” which is a nationally designed ambition, a significant driver to reduce the number of stillbirths and early neonatal deaths in England that all trusts are working towards. Evidence seen has shown that the trust had the highest stillbirth rate within the North Central London (NCL) regions reported in 2020 at 3.71 per 1000 births and extended perinatal deaths at 4.45 per 1000 births (as reported by NCL February 2023) when compared to national data.

NCL reported that the service stillbirth rate February 2023 was at 6.82 per 1000 births (above the national rate of 4.8 per 1000 births 2022 and not in line with the national ambition to reduce stillbirths) and significantly increased from the 2020 reported rate of 3.71 per 1000 births. NCL reported the service neonatal death rates in February 2023 were reported as 6.87 per 1000 births which was significantly higher than the national rate 1.8 per 1000 births this information was not comparative to either of the service’s 2 local dashboards provided by the service.

Women and birthing people from minority ethnic groups experience additional risks compared to White women that, without the right interventions, can lead to poor outcomes. For example, we know that: Black women and birthing people are four times more likely to die in pregnancy and childbirth than White women and birthing people, for Asian women it is two times more. The service had told us that they have a higher than national average non-white ethnic women and birthing people, the service reported to the national maternity data July 2023 that 51% of women and birthing people booked for maternity care are of an ethnic white category, 18 % Black/Black British, 10% Asian or Asian British with remaining ethnicities being any other, mixed, or not stated. Stillbirth rates are nationally reported as having

outcome differences between ethnicities, deprivation, and maternal age. The service had developed a number of specialised clinics for example: Iris Clinic for Female Genital Mutilation (FGM) and Haemolytic Clinic for conditions like sickle cell and thalassaemia. Additionally, there were other specialist clinics for the whole population served including: Diabetic Clinic, Perinatal Mental Health Clinic and Maternal Medicine Clinic.

Staff were not able to tell us what the service's stillbirth or neonatal death rates were, or of plans to reduce the rates. It was nationally recognised that inequalities in health can impact the maternity outcomes, NCL audit February 2023 data analysis collection from Perinatal Mortality Review Tools (PMRT) and Healthcare Safety Investigation Branch (HSIB) reports identified possible contributory factors included demographic, socio-economic information, pregnancy complications, screening, engagement with service and the need to use interpretation services. However, we did not see any plans how the service would reduce fetal loss.

Staff completed new-born risk assessments when babies were born using a recognised tool and reviewed this regularly. However, we saw incidents which showed this risk assessment was not always being completed at appropriate times or according to service policy. This included missed or delayed checks which meant babies were readmitted or had prolonged stays in hospital.

We reviewed the service submission to the national maternity dashboard and found they generally performed better that the national average for post-partum haemorrhage and 3rd and 4th degree perineal tears. However, evidence provided as part of the inspection showed there was a two-month delay in uploading data to the regional maternity dashboard.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance.

We reviewed evidence which showed a total number of 401 shifts for qualified midwifery staff for the period 06 February to 02 April 2023 evidencing that these shifts remained unfilled.

Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk. We found leaders did not always ensure there were enough senior or experienced midwives on labour ward, in addition there was not always a supernumerary labour coordinator in line with best practice guidance.

Staff consistently told us, and we saw evidence which showed the service did not have enough staff with the right qualifications, skills, training, and experience to keep women and birthing people safe from avoidable harm. Managers did not always review and adjust staffing levels and skill mix. We heard the practice development midwives and specialist midwives were often required to provide clinical care which meant they could not always fulfil their specialist roles.

We found the last full staffing and acuity exercise review using a nationally recognised tool was completed in 2020 using baseline data from April 2019-March 2020. This showed maternity services required an uplift of staff which the service reported was approved and actively recruited to. At the time of inspection, we saw the midwifery vacancy rate was 10.3%. The sickness rate for midwifery staff increased from 2.9% in March 2022 to 6.5% in December 2022, however this was consistent with seasonal pressures.

Maternity

Staffing rota's, service reports and incidents showed staffing levels were frequently below planned staffing levels. During the inspection we found the service was consistently short of registered midwives across all areas.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. We saw the service reported 68 NICE maternity red flag events in the six months prior to the inspection. The service reported these as episodes not as individual cases, which meant there was not an accurate recording of the number of women and birthing people affected. Staff told us and evidence showed that staff did not always report staffing incidents that should have been raised as a NICE maternity red flag event.

We saw evidence of ongoing delays to care, including women and birthing people who required urgent induction of labour and procedures and monitoring not being done on time, ongoing staffing, and capacity issues.

Evidence showed there were delays in induction of labour (IOL), artificial rupture of membranes (ARM) and augmentation of labour. We saw an occasion where the service reported being in 'Amber' escalation yet there were 13 women and birthing people who had experienced delays in commencing their induction. Additionally, there were three women and birthing people awaiting augmentation as inpatients. However, there were processes in place to monitor the health and well-being of each woman and birthing person during their delay.

Sadly, in addition to these 16 cases which were delayed over a three-day period there was a high-risk case of a woman or birthing person with a stillborn baby waiting at home for a telephone call to be advised when to attend the service for IOL. However due to staffing issues the service delayed bringing the woman or birthing person in for IOL.

Evidence reviewed has identified that maternity support workers are at times left without a registered professional to provide care to women, birthing people and babies without any guidance, standard operating procedure or policy in triage including postnatal care.

Minutes of service meetings as well as feedback from women and birthing people we received as part of this inspection highlighted poor service user satisfaction.

This was contradicted by evidence which showed labour ward coordinators were regularly not supernumerary, which is not line with the recommendations of the maternity incentive scheme (MIS) and Ockenden (2020 and 2022). Evidence provided by the service showed they reported 120 red flags between October 2022 and March 2023.

During our inspection we observed the service did not have the resources to adjust staffing levels according to the needs of women and birthing people, staff and managers told us that this happened daily, and they regularly moved staff according to the number of women and birthing people in the clinical area. Staff and leaders told us that staff were moved at short notice, birthing centre closed frequently, and staff were frequently expected to work in areas unfamiliar to them.

The service had an escalation policy and process in place during times of increased activity, high acuity, or low staffing this included specialist midwifery teams being placed on a roster to support clinical areas (where they feel confident and competent) and closing the birth centre on shift-by-shift basis, temporary and agency staffing review had taken place with plans to offer block contracts. Staff told us that due to a change in process and procedure that agency shifts were not being filled frequently, evidence we have seen triangulated that there were multiple unstaffed midwifery shifts.

Maternity

A review of the national reporting and learning system National Reporting and Learning Systems (NRLS) showed that between 28 October 2022 and 31 May 2023 there were 86 reports relating to staffing issues / short staffing in the maternity acute areas, 65 reports that the birthing centre was closed, eight reports of lack of staff breaks, three reports of preceptor staff and supernumerary staff being re-deployed and therefore not working supernumerary.

Staff told us that pregnant women and birthing people did not always receive 1:1 care in labour due to staffing. However, the proportion of 1:1 care in labour achieved was not recorded in board papers or senior staff reports. During the factual accuracy process the service provided snapshot audit evidence which showed for specific weeks in September, November 2022 and January and May 2023 1;1 care in labour was 100%.

Evidence showed reporting that in two stillbirth cases that two women, birthing people did not receive 1:1 care in labour, and that both women and birthing persons were not given the epidurals that had been evidenced in their personalised care plans and which they also requested during their labour.

Staff told us they had raised concerns about staffing levels with the trust board. We saw the February 2023 trust board papers reported that in 2022, 29 nursing and midwifery staff raised concerns, which had increased from 22 staff in 2021.

Bank and agency staff were used within the service, but staff told us that there were delays with the approval of agency staffing due to a complex internal process which required senior management approval and sign off. Staff told us that these delays were impacting on safe staffing levels and frequently shifts were unfilled due to lack of timeliness with the process. Staff also shared the same feelings in August 2022 as part an NHS England assurance visit. During the factual accuracy process the trust informed us there was policy on the approval of bank and agency to allow for oversight of need and appropriate governance of approval.

The service reviewed the provision of midwifery continuity of carer (MCoC) provision, following the national recommendation that trusts should review the MCoC recognising the national shortage of Midwives and the need to provide safe intrapartum care. The MCoC model of care is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwife throughout their pregnancy. Senior leaders told us that the service had considered these recommendations but had decided to continue with MCoC. However, the MCoC model adopted by the service did not include intrapartum care, continuity was only provided in the antenatal and postnatal period.

The service had two full midwifery continuity of carer (MCoC) teams being Ruby team and Homebirth team. Staff told us that the Ruby team frequently had staff shortages.

The service reported an increase of women and birthing people booked on MCoC from 44% in December 2023 to 67% in April 2023. Evidence provided showed in May 2023 98% of the women, birthing people booked for care at this service were booked under the MCoC. However, not all staff were aware of the MCoC model adopted by the service and continually reported to us. women and birthing people booked under MCoC did not always receive intrapartum and inpatient care from the MCoC midwives.

The service developed and recruited midwives to a new ‘homebirth’ team which was not part of MCoC. The home birth team had been set up to support women and birthing people wishing a homebirth against medical advice and national guidance, the leaders told us that the women and birthing people using this service were predominately from out of area but chose to transfer their care so as to obtain this home birth service.

Maternity

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

Evidence showed 68% of clinical staff in the service had received an annual review of their work.

Staff told us annual reviews (appraisals) were arranged by their managers. There were varying levels of appraisal across the Maternity service ranging from none for the Magnolia team to 88% for antenatal clinic staff. The staff survey responses demonstrated appraisals were not effective, as only 24% of labour ward staff and 25% of maternity ward staff articulated that appraisal helped them to improve how they did their job. There was limited capacity for clinical supervision as there was only one professional midwifery advocate (PMA) in post. Staff reported they would use their appraisal for clinical supervision.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep woman and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Staff told us locum doctors were well supported and received a comprehensive induction. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Medical staff reported improved results from the General Medical Council (GMC) trainee survey. In the 2022 survey, the score for workload was significantly better than the national average. The score for adequate experience was worse than the national average. This was an improvement from the 2021 results.

The service had an obstetric lead and additional consultant lead roles for fetal medicine, risk, and labour.

The service told us that they used locum consultants at a ratio of one in 17 shifts. Staff told us ward medical ward rounds took place in the morning and the afternoon. The triage unit was open 24 hours a day, seven days a week, and staff told us that it is covered by a specific registrar 08:00-20:00 hours daily which we observed on the day of inspection.

Consultant presence in the maternity unit was in accordance with the Royal College of Obstetricians (RCOG) with a monthly audit showing 100% compliance.

The Obstetric vacancy rate was 5.4 WTE (Whole Time Equivalent) for junior doctors and the service was using locums to cover this shortfall.

Medical staff told us there was good team working amongst the consultants and the midwives, but they told us they felt the midwifery staffing remained a problem.

Medical staff received support from a college tutor, meetings, in house support group for doctors, hot debrief, cold debrief and the availability of a well-being room.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up-to-date, and easily available to all staff providing care as both paper and electronic records are in use.

Care records were not always comprehensive, and staff could not access all relevant information easily due to a combination of paper records and multiple electronic systems in use in some areas and no overarching electronic patient record (EPR) system. For example, paper records reviewed in the triage area were often incomplete and not transferred to electronic records to aid communication between teams. In most clinical areas women and birthing people's notes were not always easily accessible. Staff also told us, and we observed, not all clinical interactions were recorded at the time of activity. This included information required for each woman and birthing person on arrival. We did not see evidence that risk assessments were documented at this time.

The service used paper records and a historic electronic patient record. The patient care record was used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was to be used to share information between care givers; however, midwifery and medical staff told us there were often challenges obtaining all relevant documentation. During the factual accuracy process the trust told us they were in the process of commissioning an end-to-end electronic maternity record system. We asked for the most recent Cardiotocograph (CTG) audit, the service provided an audit which was completed in December 2022 following six significant cases related to CTG misinterpretation and a further eight cases between July 2019 and October 2020. Evidence showed in all 14 cases there was inadequate record keeping and documentation in 100% of all cases reviewed.

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 prescribe, administer, record and store medicines, however these were not always administered appropriately.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

Staff reviewed each woman or birthing person's medicines regularly and provided advice to women 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 told us and we saw evidence which showed there were delays with women and birthing people waiting for medications to take home. We were told there were gaps in pharmacist cover for the wards which had led to delays. However, during the factual accuracy process the trust told us a team of pharmacists covered maternity services during May 2023.

Maternity

During our onsite inspection we found that systems and processes to prescribe, administer, record and store medicines were in place. Staff told us and we saw evidence which showed there were times when medications, blood products and analgesia were delayed due to staffing. We also saw drug errors reported which included a woman or birthing person given a medicine they were known to be allergic to. During the factual accuracy process the trust confirmed the incident was reported and reviewed and actions completed.

We saw delays in giving analgesia reported in complaints and incidents, these included delays in epidural (as per birth plan) and an alternative analgesia provided, medication error incorrect dosage of medication and poor documentation reported.

We saw that ward stock drugs were stored and checked in line with local policy.

Incidents

The service did not always manage safety incidents well. Managers did not always investigate incidents and lessons learned were not always implemented to improve services. However, staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored. Incidents reported were not always reviewed or acted upon in a timely manner.

Incidents were not always investigated in a timely manner to manage risk and identify opportunities for learning or changes in practice to reduce the recurrence of harm. Managers did not investigate and respond to incidents in a timely way to identify potential immediate actions. Evidence provided as part of the inspection showed in April 2023 that there were 319 open incidents. Of these, 31 were outstanding, 16 awaiting review, seven were open Healthcare Safety Investigation Branch (HSIB) cases and four were open serious incidents. There were no outstanding serious incidents.

Staff knew what incidents to report and how to report them, however, despite staff being encouraged to complete incident reports, they also articulated to us they felt they were “criticised or bullied for doing so.” We heard that the criticism or bullying was worse if the incident reported was relative to other staff and their perceived behaviours.

Multiple staff and managers told us they did not always report incidents where there was a lack of 1:1 care in labour or if the ward coordinator was non supernumerary.

A review of incidents reported to the national reporting and learning system between October 2022 and May 2023 showed the service had not always reported incidents appropriately. We found two incidents which met the NHS England criteria of a Never Event; however, these were reported as low harm and duty of candour was only carried out in one case. Never Events are serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

There was limited evidence that the service learns from incidents and completes the appropriate agreed relative identified actions.

Healthcare Safety Investigation Branch (HSIB) make safety recommendations in their reports, the findings that HSIB identify are provided to organisations with the opportunity to learning and change that may impact in different circumstances at the time of our inspection, we found that Healthcare Safety Investigation Branch (HSIB) recommendations from a January 2022 case made to the trust “The trust to ensure that at every clinical contact a risk

assessment occurs and is clearly documented and communicated" and "the trust to ensure that clinicians are supported to undertake timely and holistic assessments that help mothers made informed decisions about mode and place of birth" we have seen evidence these actions had not being completed, the service not been implemented recommendations and risk assessments were not being used in triage.

We have seen evidence of other incomplete Healthcare Safety Investigation Branch (HSIB) safety recommendations actions which included "for all staff to be trained in waterbirth pool emergency training" however training evidence provided by the service confirms that this has not occurred despite waterbirths being facilitated.

The service failings in completing the Healthcare Safety Investigation Branch (HSIB) safety recommended actions are exposing women, birthing people, and their babies to the risk of harm.

Managers did not always proactively debrief and support all staff after any serious incident; some staff did say they could seek support if they wanted it. However, during the factual accuracy process the trust informed us there were a number of support mechanisms for staff including, discussions at the multi-disciplinary team (MDT) Friday cardiotocography (CTG) meetings, individual consultations with education and fetal monitoring teams, and access to the Risk and PMA Teams. Staff were able to verify Healthcare Safety Investigation Branch (HSIB) reports for factual accuracy and access a dedicated Support Group led by the Trust's wellbeing team.

The service completed a thematic review of 'round table' of patient safety incidents May 2023 of which four cases were reviewed, all four women and birthing people were high risk with three of them being induction of labour (IOL) and one for artificial rupture of membranes (ARM). Safety actions and common themes recognised as CTG misinterpretation in 2nd stage of labour, the use of oxytocin with an already compromised CTG, escalation pathway not used, inadequate fresh eyes and the loss of situational awareness by the co-ordinator and a lack of senior involvement in all three cases. These themes were recurrent from HSIB & Perinatal Mortality Review Tools (PMRT) reports evidencing that lessons have not been learnt from previous incidents.

Staff understood the duty of candour. However, the service was not always open and transparent and did not always give women and birthing people and families a full explanation when things went wrong. It was not clear duty of candour was always applied when it should have been. Operational staff we spoke with could not recall any instances where duty of candour had been carried out.

We reviewed serious incident investigations and found staff had not always involved women and birthing people and their families in the investigations. PMRT review documents noted families had provided feedback to show there was a lack of support and information provided, and a limited number of cases shared families' perspectives with staff.

We saw serious incident reviews that showed a lack of evidence of Duty of Candour when PMRT had been carried out. This was the case where the service had identified care may have caused harm such as stillbirths, neonatal deaths, or brain injuries to babies.

Multiple cases of Perinatal Mortality Review Tools (PMRT) identified care issues including inappropriate management given their history including smoking cessation and lack of referral to service to support smoking cessation.

Growth screening was identified in cases where women, birthing people "had risk factor(s) for having a growth restricted baby but several scans were not performed at correct times / intervals", "there were concerns about the baby's growth rate, but these were not investigated and acted upon appropriately".

Maternity

PMRT's identified that from the 22 babies reported "grading of care relating to babies who died in this period and for whom a review of care has been completed", however the gradings of care reported by the service included 17 cases not 22.

The PMRT review group reviewed the grading of care of the mother and baby up to the point that the baby was confirmed as having died. Evidence provided by the service showed in 12 of the 17 baby deaths there was care issues identified.

The PMRT review group reviewed the grading of care of the mother following the confirmation of the death of baby. Evidence provided by the service showed in 10 of the 17 baby deaths there was care issues identified.

The PMRT review group also completed PMRT's on neonatal and post-natal baby deaths. Evidence provided by the service showed in three of the five baby deaths there was care issues identified.

Healthcare Safety Investigation Branch (HSIB) and PMRT have reported the service have failed to send several placentas for histology testing, therefore losing possible evidence that may be gained from a histopathological examination of the placenta following a pregnancy affected by medical complications, pregnancy loss or neonatal death may provide an explanation of why this occurred. This explanation can be beneficial to the patient to understand and make sense of what has happened. It may also provide information relevant to the management of the associated infant and/or subsequent pregnancies and be of use to serious incident reviews and other audits of patient care.

We saw some PMRT reports where care issues have been identified but not graded in accordance with the PMRT "gradings related to care statements" therefore have not been reporting care issues which may or likely had made a difference to the outcome for the baby or mother.

No action plans or action plan trackers have been evidenced by the service relating to PMRT's to evidence lessons learnt. Managers did not always investigate incidents thoroughly. Investigation reports did not always include details of the involvement of women, birthing people and their families in investigations and monitoring of how duty of candour had been completed.

In all cases it was not clear if investigators and managers shared duty of candour and draft reports with the families for comment. Managers did not review incidents potentially related to health inequalities.

Staff told us they didn't always receive feedback from investigation of incidents, both internal and external to the service. There was not always evidence that changes had been made following feedback including completed actions from Healthcare Safety Investigation Branch (HSIB) safety recommendations.

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Maternity

Local leaders did not always have the skills and abilities to run the service, they were not always visible and approachable in the service for women, birthing people, and staff. Executive leaders did not always manage the priorities and issues the service faced to ensure a safe effective responsive service.

The maternity service sat within the Division of Women's and Children's Services which included obstetrics, gynaecology, and paediatrics.

The service was led by Divisional Director of Nursing and Midwifery, Associate Director of Midwifery, Clinical Director, Deputy Head of midwifery and Business Operations Manager.

The senior leadership team known as 'triumvirate' reported to the Divisional Clinical Director, Divisional Director of Operations and the Divisional Director of Nursing Midwifery and Allied Health Professionals. The Head of Midwifery held the title of Associate Director of Midwifery.

We heard the executive team were not visible in the maternity service and rarely visited the wards. Despite the service being supported by maternity safety champions and non-executive directors, staff were unable to tell us who the maternity safety champions were.

We were not assured local leaders fully understood the challenges and issues within the service. We did not always see improvement plans translated into tangible actions and improvements, particularly as some of improvement and issues had been identified during our previous inspection in 2018.

Managers told us they had implemented an education and quality improvement plan, and that there was additional money secured for a second Professional Midwifery Advocate (PMA) to support midwifery staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, which had been developed with relevant stakeholders. The vision and strategy acknowledged the importance of sustainability of services and alignment with local plans within the wider health economy. However, staff were not able to tell us about the service's vision. The staff told us that the service's forward vision was focused on continuity of carer and homebirth services.

The service leaders had developed a vision and strategy for what it wanted to achieve to turn it into action. The framework 'ten strategic ambitions' till 2025, provided a framework to support the service in their vision to delivery outstanding health promotion, timely and harm free nursing and midwifery care in collaboration with professional colleagues and partner organisations to enable local people keep healthy. Not all staff were not involved in the creation of the service vision and strategy, we saw evidence which showed band seven midwives were part for the strategy. Staff we spoke with during the inspection were unable to tell us about the services vision and strategy.

The vision of the service was described as 'promoting population health and delivering outstanding, timely and harm free care', which was built upon the principles that women and birthing people remain healthy, improved outcomes for women and birthing people and service users with improved pathways whilst having an outstanding experience.

The vision and strategy referred to local health inequalities and Integrated Care System (ICS) alignment and integration, albeit not comprehensively or with any forward plans.

Maternity

During interviews leaders told us they had a good understanding of the nature and demographics of the population they were serving, and service leaders talked of importance of addressing their specific needs. However, we did not see any tangible evidence that actions had been taken to improve outcomes or the experience of women and birthing people from different populations.

Staff told us that they did not feel that they were informed or involved in plans and strategies to address the current issues faced with the maternity unit. For example, some staff restructuring had taken place without any prior consultation.

Culture

Staff did not always feel respected, supported, and valued. The service did not always have an open culture where staff could raise concerns without fear.

A limited number of staff told us they felt supported, respected, and valued. We reviewed the results of the services NHS staff survey for the obstetrics and gynaecology workforce in 2022. All staff were invited to participate in the survey and 161 responses were received from staff including midwifery, medical and administration staff.

The survey showed that almost two thirds of ward based midwives reported they had not experienced discrimination from managers or team leaders, showing the environment to be worse than expected. The labour ward results showed a few numbers of midwives reporting they had not experienced discrimination from their managers, team leaders or other colleagues however data also shows this to be worse than expected with both areas' results being higher than the service's organisational comparison value.

The survey reported junior doctors scored positively indicating no junior doctors reported they had experienced discrimination.

The survey asked a question relating to staff feeling they had experienced harassment, bullying or abuse from other colleagues. The results for the maternity ward midwives showed that 66% of them felt they had not experienced harassment, bullying or abuse from other colleagues, showing the service reported this being higher than the comparison value of 45%. Results differed for different areas and groups of staff, for example, 80% of senior medical staff and 63% of specialist midwives did not report harassment, bullying or abuse from other colleagues.

The survey revealed low numbers of staff who felt there were "enough staff at my organisation to do my job properly." Just 6% of maternity ward staff and 11% of labour ward staff, and 13% of senior medical staff felt there were enough staff. Thirty four percent of junior medical staff felt there were not enough staff at the organisation to do their job properly and 17% of respondents neither agreed nor disagreed with the statement.

Responses reviewed from the North Middlesex University Hospital NHS Service (NMUHT) staff survey 2022 supported the information staff shared with us and their perception of working in the service as unpleasant. Some staff described a 'toxic' environment, where bullying, intimidation and undermining behaviours continued by local management and senior management.

Staff told us that they focused on safely meeting the needs of women, birthing people and babies receiving care, a large number of staff told us they felt some service managers and leaders had minimised concerns which had been escalated. We saw some evidence of this where responses to staff raising concerns about patient safety appeared to lack a recognition of the issue being raised.

Maternity

We heard staff were encouraged to incident report incidents where there was any bullying, inappropriate management of care or internal cultural issues. Staff who had reported bullying told us that they felt there was detriment for doing so, we have seen evidence to corroborate this. We also heard incident reporting was often discouraged, as incidents were ignored. Staff told us they had at times felt belittled and laughed at by colleagues and managers.

We have reviewed evidence indicating a poor culture within the maternity service. We have seen pieces of evidence suggesting a closed culture could be developing at this service, complaints includes that staff had allegedly refused to provide analgesia to women and birthing people in labour, there were complaints of selective delays in basic cares, and complaints have been seen regarding the communication manner of some of the staff towards women and birthing people. Healthcare Safety Investigation Branch (HSIB) have previously reported to the service that staff had been met with hostility from other clinicians when they have used an emergency buzzer during escalations.

Medical staff did not communicate there were any bullying or harassment concerns.

We found and saw evidence that there continues to be an ongoing relationship breakdown between the Maternity Voices Partnership (MVP) who were not able to carry out their role and as an extract shared from the Ockenden assurance visit report August 2022 showed “work is needed to build a functioning Maternity Voices Partnership (MVP) with a shared vision and good working relationships. The Local Maternity and Neonatal System (LMNS) and regional team will support those involved, who are passionate about improving maternity services, for the most vulnerable service users”.

Staff and MVP told us that the service had not engaged with them, some reported that the service leaders’ behaviours were reported as being intimidating at times towards other agencies.

The service and MVP had been in mediation prior to the Ockenden assurance visit, however we have evidence the relationship remains fractured and non-functioning. The service was trying to engage with women and birthing people outside of the MVP, however we are unable to comment on how effective this has been. This meant we could not be assured the service was compliant with the maternity incentive scheme (MIS) safety action seven and using the service user feedback and working with the MVP to co-produce local maternity services.

The service had received eight complaints in the three months prior to our inspection, six of which remain open. We have seen these complaints and found themes reported by women and birthing people included poor patient experience cited poor care, and lack or delays in receiving analgesia, poor communication, and attitude as well as an alleged never ever event. These same themes were also reported from the parents’ perspectives in some of the Perinatal Mortality Review Tools (PMRT) reports we reviewed. There was no evidence of using complaints to drive forward change, staff told us that they didn’t get feedback from complaints or incidents.

Some medical staff told us that there was a cohesive culture of co-working, however other medical staff told us that they perceived there was bullying and harassment within the midwifery staff. Some medical staff felt that midwives didn’t hesitate to challenge doctors as necessary which was regarded as a positive multi-disciplinary team (MDT) working factor.

Healthcare Safety Investigation Branch (HSIB) reported “the trust to ensure that clinical staff are empowered to communicate in a clear and effective way when escalating to other clinicians for support” following an investigation which identified staff had not effectively communicated during an emergency and staff had not used the emergency buzzer system due to staff providing care knew that other ward staff were busy.

Governance

Maternity

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were not always clear about their roles and accountabilities. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate an effective governance process throughout the maternity service. The service provided a clear governance structure and processes to support the flow of information from frontline staff to senior managers. However, we found the governance structure and processes were not embedded. We found leaders did not always monitor key safety and performance metrics and there was a lack of evidence of lessons learnt and subsequent improvements to practice.

The service provided evidence which showed recommendations from August 2022 to instigate a robust process to ensure safety actions were fulfilled. In addition, the service was advised to implement and monitor the effectiveness of risk assessments through audit. However, our inspection found there was limited progress made on these recommendations.

We found that governance systems were not operating effectively to ensure risk and performance issues were identified, escalated appropriately, and addressed with timely action to keep women, birthing people, and babies safe.

The service's governance and risk processes were not effective in identifying failings, learning from incidents, or evidencing changes to practice to prevent recurrence. Some incidents were not investigated or acted upon in a timely manner to monitor and manage risk and identify opportunities for learning or to implement changes in practice to reduce the risk of harm.

Incidents reported by the service evidenced delays in women, birthing people having cardiotocography (CTG), delays to induction of labours due to lack of appropriate equipment which was ongoing at the time of inspection.

We found inconsistencies between the reporting in managers meetings and departmental governance meetings to what was reported in board papers. For example: trust board papers from February 2023 showed the service was compliant with all safety actions under the Maternity Incentive Scheme 2022. We found that the compliance reported by this service has been based on evidential partial compliance and anticipated planned compliance trajectory.

Staff were not always clear about their roles and accountabilities, but they did not have regular opportunities to meet, discuss and learn from the performance of the service or incidents. For example, actions and lessons learned from Perinatal Mortality Review Tools (PMRT) and HSIB investigation recommendations.

The service had been advised to invest in a new maternity information system as a matter of urgency given the long-known impacts on risk, clinical practice, efficacy and learning as described by staff to the assurance visit team as reported by the Ockenden assurance visit report August 2022.

Management of risk, issues, and performance

The service did not use effective systems to manage performance effectively and safely. They did not always identify and act to minimise risks and issues relating to safe care of women, pregnant people, and babies. The leaders did not complete and ensure changes in practice were made as agreed from action plans to improve safety and performance.

Maternity

Maternity service leaders were not always able to provide audit programme details or audit results. The April 2023 clinical audit report provided by the service displayed conflicting information to the previous report. We found that the service's annual audit program for maternity services 2022-2023 did not include an Situation, Background, Assessment, Recommendation (SBAR) audit, risk assessment training, BLS and learning from incidents training. However, the annual audit plan did include records audit, World Health Organisation (WHO) checklist, consultant presence of labour ward, multidisciplinary presence, LOCSSIPS and the five elements of the saving babies lives care bundle.

This audit plan did not include the adherence to the Saving Babies Lives recommendations for screening nor the Maternity Incentive Scheme. The service had not completed relevant clinical audits including the national perinatal mortality audit.

The leadership team did not always take action to make change where risks were identified. Managers and staff did not complete a comprehensive programme of repeated audits to secure assurance of improvements over time. Leaders did not effectively share and make sure staff understood information from the audits and incidents.

The service had a risk register to address risks such as concerns around staffing, equipment, and estates and was discussed in the service's women and children's governance meetings. Not all risks discussed with the inspection team were included in the register such as escalation of midwifery staffing concerns and escalation of clinical risk.

We found the service was not able to effectively manage all its known risks using the risk register process. The risk register we reviewed did not provide assurance all risks were recorded and scored appropriately. We found data submissions had not always been completed or completed to an appropriate standard. For example, the ongoing and continued risk of a lack of cardiotocography (CTG) machines identified during the inspection. Following the inspection, the service provided assurance this had been actioned.

Leaders did not have an established clinical risk process and did not have full oversight of all risks to patient safety. Following reports and recommendations from investigations carried out by Healthcare Safety Investigation Branch (HSIB) there was a lack of evidence that effective tangible actions with pace to deliver and lessons learnt had been identified or shared. We saw recurring themes of safety recommendations and actions that had not been addressed for example a recurrent lack of risk assessments being completed.

Leaders did not always identify and escalate relevant clinical risks, issues, or actions to reduce their impact. Staff told us not all risks were identified through the incident management system and risks were not always reviewed and recorded in meeting minutes for the monthly risk assurance meeting.

NHS England publication PR2011 was sent to all trust chief nurses, director of midwifery and trust CEO's 21/09/2022 advising them to set out essential and immediate changes to the national maternity programme in light of the continued workforce challenges that maternity services faced, and that there would no longer be a target date for service to delivery Midwifery Continuity of Carer (MCoC) and that local service to be supported to develop local plans, as the top priority for maternity services must continue to be ensuring that the right workforce is in place to serve women, birthing people and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe, and personalised maternity care, before, during and after the birth. It is a model of care provision that is evidence-based, however this service have evidenced that the Midwifery Continuity of Carer (MCoC) is focused on women and birthing people with Perinatal Mental

Maternity

Health needs and women and birthing people who have had a previous caesarean section and is not a fully inclusive MCoC service. MCoC can improve the outcomes for most women and babies and especially women of Black, Asian, and mixed ethnicity and those living in the most deprived neighbourhoods, however the service has not developed this as an element of MCoC, this model of care requires appropriate staffing levels to be implemented safely.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths.

NHS England September 2022 recommended to all trusts "trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision".

We have seen evidence the MCoC model used by this service was impacting on the safety, quality, and sustainability of the service, this had not been acknowledged and communicated to staff. The service had reviewed the model of care and made the decision to continue with MCoC despite the ongoing issues with safe staffing in the acute setting. Additional staff were recruited to the MCoC and homebirth teams despite the continuing staffing pressures within the acute setting. We heard from our conversations with staff how this had negatively impacted on their morale.

Evidence submitted to the trust board showed the service continued to focus on developing a full MCoC service and stated, 'staffing issues remain but are improving.' at the time this was reported it was evidenced that the midwifery vacancy rate was at 16%.

Evidence showed leaders were aware of patient safety risks and challenges throughout the maternity service over a prolonged period. Leaders had not begun to implement or completed actions to ensure the safety, quality, and sustainability within the service. Staff continuously told us leaders were not responsive; staff had felt that leaders had been dismissive when issues had been raised with them.

Information Management

The service did not always collect and analyse reliable data or analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were not consistently submitted to external organisations as required. The information systems were not integrated and however they were secure.

The process in place for introducing, communicating new or amended policies was not effective. This meant staff did not have access to up-to-date local or national policies to plan and deliver high quality evidence-based care. Not all policies and guidance were in date or reviewed every three years and not all staff could access the policies and guidance, the training needs analysis and triage guidance were both found to be out of date. The trust reported in April 2023 that 42 policies and guidelines had expired. A further 14 guidelines were due to expire June 2023, and 15 due to expire in July 2023. We were not assured plans were in place to rectify this position.

We found the service did not always submit data to the national maternity services data set (MSDS) and some of data submitted has not met the MSDS required standard.

Maternity

We requested a copy of the service's maternity performance dashboard used by senior managers. The services maternity performance dashboard provided by the service was shown as not being effective, the purpose of the maternity dashboard is to enable the service to benchmark activity, monitor performance, to plan and improve their maternity services through clinical governance monthly. This is a framework whereby NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care.

The service provided three dashboard summary charts which showed key performance indicators and performance over time for some but not all metrics. There was no evidence that measurable action plans were put into place for key metrics outside of target. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Staff told us and we did not see evidence that the maternity dashboard information was shared widely throughout the service.

The service maternity dashboard data did not contain any data relating to the number of babies with Hypoxic-ischaemic encephalopathy (HIE) or numbers of cases referred to Healthcare Safety Inspection Branch (HSIB) and neonatal deaths. We found no evidence to support the service measuring these outcomes.

The national maternity data set data identified that these were higher (worse) than the national average, however there were dedicated maternity and midwifery stop smoking advisors to improve this position. Staff could not always find the data they needed in easily accessible formats to understand performance, make decisions and improvements.

We found that there were inaccuracies with the data, and this was particularly the case when they used three separate maternity dashboards containing inconsistent data. The service provided data that told us that they had made eight Healthcare Safety Inspection Branch (HSIB) referrals for the previous six months, yet there was also evidence which showed the number of cases referred to HSIB October 2022 – March 2023 was 13 cases.

We found that the maternity dashboards for NCL December 2022 – February 2023 were presented two months late, and March 2023 was being prepared for submission in June 2023. We found the inconsistencies in the data as the service dashboard April 2022-March 2023 reported one intrapartum stillbirth, however between October 2022 and March 2023 three intrapartum stillbirths had been reported to Healthcare Safety Investigation Branch (HSIB). We also found 11 HSIB reportable cases between April 2022-March 2023 were not reported or monitored on the local dashboard. Therefore, the service could not be assured the correct data was provided or recorded in the maternity dashboard.

The Perinatal Mortality Review Tools (PMRT) summary report for April 2022 to March 2023 showed inconsistent standards of completion, quality, and accuracy. There was also a lack of evidence of duty of candour, evidence of lessons learnt, external engagement in completing reviews with no external participation being recorded during the 12-month period of the report. This summary report was also not accurately reflected in risk, governance, or service reports.

We found clinical information systems were not always integrated, with an aging electronic patient record system and reporting system alongside the lack of electronic paper records. Ockenden Assurance visit August 2022 reported "the trust should invest in invest in a new maternity information system as a matter of urgency given the long-known impacts on risk, clinical practice, efficacy, and learning". We saw this had been included on the service risk register, however we saw no evidence this had been commenced.

Engagement

Leaders and staff did not always actively and openly engage with women, birthing people, and staff. There was a lack of collaboration with equality groups, the public and local organisations to plan and manage services.

Maternity

We found a lack of service engagement with the Maternity Voices Partnership (MVP) due to the complete breakdown of that relationship. Evidence provided showed MVP meetings continued to be held, however there was no MVP representative present. This lack of engagement led to limited, or no development of the service working to improve the health of the local population and reduce health inequalities. We heard the North Central London regional transformation midwife and service user lead for London had offered to support a co-production of a shared MVP division and development of roles but no evidence of this has been shared.

We saw the information provided to women did not meet the needs of the local population due to the limited number of languages they were translated into. Feedback from women, birthing people and families identified there was an absence of appropriate, relevant information which resulted from the lack of translation services being used. We saw posters were displayed with information regarding chaperone, safeguarding, housing, homelessness, and domestic violence, and we saw family and friends' information displayed. However, we saw the chaperone posters were only available in three languages,

The 2022 CQC maternity survey responses reported were not representative of the population diversity. The survey showed 38% of feedback was positive, however, there were themes which included staff being rude, impatient, angry, delays in care and delays in answering buzzers, lack of support postnatally, lack of respect of women and birthing people's beliefs and wishes including, their dietary choices. Evidence provided showed that they had also identified rudeness and staff not being kind, with the service giving an action that this would be included within staff training. The service did not hold regular engagement sessions with staff and women, birthing people and families who used the service. We did not see how feedback was used to make improvements or changes to the service.

Learning, continuous improvement and innovation

Staff did not always have the skills and resources to implement improvements to services and these were not always timely or evidenced as being implemented.

Despite staff telling us they were personally committed to learning and improving services there were missed opportunities for this. Quality improvement was routinely discussed at service meetings, quality improvements and action plans such as those following Healthcare Safety Investigation Branch (HSIB) investigations and Perinatal Mortality Review Tools (PMRT) reviews. However, evidence showed staff had repeatedly reported the lack of acknowledgement of staff ideas and suggestions for improvements. Leaders stated they promoted change and improvement through training and innovation. However, staff said there had been nothing developed or shared. During our interviews with staff, we were consistently told that there were limited meaningful changes to practice following quality improvement discussions and action plan formulation.

Staff did not always have an awareness of the service's quality improvement methods and were not always given the time or skills to use them. There was no evidence the service was committed to improving services by learning when things went well or there were lessons to be learned and there was a lack of action taken to follow up plans and learning. Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support clinical research studies.

There were plans in place to develop and provide 24-hour bereavement cover to improve the bereavement service for women, birthing people, and babies. This included a plan to release and train staff in the perinatal post-mortem consent training.

Maternity

The Magnolia team was created by midwives to meet the needs of service users, using a multi-disciplinary team approach to provide perinatal mental health support to women and birthing people. The team provided individualised care and support to support their mental health needs, ensuring they received the right perinatal mental health support at the right time.

The service was a member of the North Central London (NCL) 'Start Well' programme which aimed to ensure hospital-based maternity, neonatal, and children and young people's services fully met the needs of those who used them. The proposed care models for maternity, neonates, and children and young people's surgery could potentially lead to changes in how services were organised in NCL, the Integrated Care Board (ICB) had agreed a recommendation to move to a formal options appraisal process which would identify potential implications and recommendations for next steps.

Areas for improvement

Action the trust 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 MUST take to improve:

Maternity

- The service must ensure there are sufficient midwives. The service must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced midwives in order to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies. (Regulation 18)
- The service must ensure training is completed and that staff are compliant against national and local trust targets, including but not limited to emergency evacuation of the birth pool, patient group directive medicine, human factors training, safeguarding, and that all staff complete risk assessment training. Any staff who have not received the appropriate training must have adequate mitigation in place. (Regulation 12)
- The service must ensure staff are up to date with maternity mandatory training modules and that all staff complete regular skills and drills training. (Regulation 18)
- The service must ensure staff are competent in competent in the use of fetal scalp electrodes, carrying out cardiotocography (CTG) and in the interpretation of CTG monitoring on reviewing, escalating an emerging or evolving concerns appropriately. (Regulation 12)
- The service must ensure all staff receive an annual appraisal. (Regulation 12)
- The service must ensure there is sufficient equipment including emergency resuscitation and CTGs to care for women, birthing people, and babies throughout the unit. (Regulation 15)
- The service must ensure that the appropriate risk assessment takes place at each contact when women, birthing people are admitted to the service, or when attending triage. (Regulation 12)
- The service must review processes within the maternity triage and ensure that care, reviews and waiting times for women are appropriate, risk based and monitored for efficacy and safety. (Regulation 12)

Maternity

- The service must ensure systems and processes for maternity triage are reviewed so to deliver a safe service in line with national guidance. (Regulation 17)
- The service must ensure adequate standards of documentation is maintained, including but not limited to CTG monitoring, patient observations, medicine charts and handover of care. The Service must ensure that patient records are stored securely at all times. (Regulation 17)
- The trust must ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care. (Regulation 12)
- The trust should ensure effective measurement of acuity in all areas to enable appropriate and sufficient staffing to provide safe care. (Regulation 12)
- The service must ensure staff complete daily checks of emergency equipment. (Regulation 15)
- The service must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and escalated appropriately. (Regulation 12)
- The service must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care. (Regulation 12)
- The service must ensure there are effective governance processes and systems to identify and manage incidents, risk, issues, and performance and to monitor progress through completion of audits, actions and improvements and reduce the recurrence of incidents and harm. (Regulation 17)
- The service must ensure that all incidents are reported internally and externally in line with trust policy and national requirements, investigated thoroughly and that learning from incidents is shared. (Regulation 17)
- The service must ensure performance audit programmes are carried out, completed appropriately, and reported in line with national standards and guidance. (Regulation 17)
- The service must ensure compliance with recommendations and reviews are carried out effectively to ensure actions and changes in practice are completed and performance is reported correctly. (Regulation 17)
- The service must evidence lessons learned and changes to practice and care following on from reviews, recommendations, and reports. (Regulation 17)
- The service must ensure the culture within the service significantly improves so that it does not impact upon service user safety and care. (Regulation 18)
- The service must ensure they engage with women, birthing people, the local communities and groups, the Maternity Voices Partnership representatives, and families to listen and involve them in service investigations, reviews, and jointly develop a 'personal care' service to meet the needs pertinent to the services demographics & population. (Regulation 17)
- The service must ensure Duty of Candour is carried out appropriately. (Regulation 20)
- The service must ensure that they have effective systems and processes as to not delay the safe care of women, birthing persons attending the service for induction of labour (IOL) or artificial rupture of membranes (ARM). In the event of the induction of labour (IOL) and the artificial rupture of membranes (ARM) care been delayed the service must risk assess and ensure individualised person-centred care plans are in place to mitigate risks delays may pose to these persons. (Regulation 12)
- The service must ensure that there are there are an appropriate number of Dawes Redman CTG machines to be used in providing care and treatment to women, birthing persons in a safe way to meet their needs. (Regulation 12)

Maternity

- The service must offer translation services for all women, birthing persons where English is not their first language for all risk assessments, advice, plans of care and when seeking consent. (Regulation 12)

Action the service SHOULD take to improve:

Maternity

- The trust should ensure staff are encouraged and supported to report staffing problems and act upon them appropriately.
- The trust should ensure leaders are visible, approachable, acknowledge and manage the issues throughout the service.
- The service should use translation services, systems, and processes to gain service user feedback.
- The service should accurately communicate reported findings shared by agencies in reports, recommendations, and actions.
- The trust should ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care.
- The service should ensure that all members of the Multi-disciplinary team (MDT) attend delivery suite ward rounds and safety huddles. The service should ensure there is a records system that is clear, complete, and up to date to enable staff to provide safe and effective care.
- The service should ensure that duty of candour is carried out for all eligible incidents.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 4 other CQC inspectors, 1 inspection manager and 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.