Royal Free London NHS Foundation Trust

Barnet General Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Our findings

Overall summary of services at Barnet General Hospital

Inspected but not rated

We carried out an unannounced focused inspection in the maternity unit of Barnet Hospital on 4 June 2021. We did not rate the maternity service on this occasion and the rating of good remains for the service.

Although Barnet Hospital's maternity service had not been inspected since August 2016, when we rated it good overall, we carried out an inspection because we received information giving us concerns about the safety and quality of maternity services.

As this was a focused inspection, we only inspected three of the key questions in maternity services (safe, effective and well led).

Focused inspections can result in an updated rating for any key questions that were inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

We inspected maternity care throughout the unit so we could get to the heart of the service user experience. During the inspection, we needed to understand the women's journey and make sure that women and babies were kept safe from harm and that staff were supported with their training and decision making. To do this we visited the antenatal, triage, maternity day assessment unit (MDAU), the antenatal/postnatal ward (Victoria ward), the Labour ward and the midwifery led birth centre.

We did not inspect the community midwifery teams because the services were carrying out care within the community. The maternity services were in the process of making the changes necessary to meet improvements identified following a recent inspection at the trusts other maternity site. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

How we carried out the inspection

The inspection was led by one CQC inspector who was supported by an experienced obstetric specialist advisor and a midwifery specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

On the day of the inspection, we visited five key areas of the maternity unit. We observed two staff handovers/safety huddles, five episodes of women care and spoke with two women. On site we reviewed 14 sets of electronic patient records and seven maternity guidelines.

We spoke with five band 6 midwives, six band 7 midwives, three specialist midwives, including the practice development midwife, the midwives who monitor and investigate incidents and oversee risks, one support worker and one student midwife. We also interviewed two of the consultant midwives, one for the Barnet General Hospital site and cross site community consultant midwife, four consultants, four junior doctors, two registrars, the medical risk lead, the clinical director for the Barnet site, and the cross site group director of midwifery.

Our findings

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

Maternity

Good

We did not rate this service at this inspection. The previous rating of good remains. We found:

- Following a recent CQC inspection at the trusts other maternity site, the trust had made improvements at this site.
- Midwifery and support staff kept up to date with their mandatory training.
- The mandatory training was comprehensive and met the needs of women and staff.
- Staff knew how to identify adults and children at risk of abuse or suffering from significant harm and worked with other agencies to protect them.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.
- The trust recently won the capital midwife quality mark for delivering a program that continued to support and develop new midwives' knowledge and skills.
- Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.
- The Women's and Children's Division had made improvements to the incident reporting and review process. The unit managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Leaders had improved governance processes and operated effective processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- Birthing pool cleaning was not routinely audited, which meant the service could not have full assurance that women and babies were kept safe from infection.
- Staff told us that delays in medical reviews would often affect the timely management and treatment of women and that service managers did not audit wait times regularly.
- Some records were paper only and detailed medical records, which contained the mother's medical history, were not available at booking in appointments.
- Daily cross-site huddles were not always attended by the delivery suite consultants and co-ordinators at the unit which meant they were not involved with planning the day's activity throughout the unit. This was not in line with national guidance.

Maternity

- Managers did not routinely monitor wait times in the maternity day assessment unit. Staff told us that delays in medical reviews would often affect the timely management and treatment of women and that service managers did not audit wait times regularly.
- The Maternity Voices Partnership told us that although their relationship with the care group had improved midwifery staff sometimes left the initiation of service user engagement to the MVP. However, the responsibility is on the trust to ensure that women are given full choice and control over their care and as part of that, that they are aware of the MVP and how to access it.

Is the service safe?

Inspected but not rated

Mandatory training

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

All staff completed and kept up to date with their mandatory training. The service had one full- time and one part-time practice development midwives (PDM). PDM's were responsible for organising, implementing, and reviewing training packages based on the most recent evidence and as a response to serious incidents.

Mandatory training was comprehensive and met the needs of women and staff. Training modules were currently accessed online due to the social distancing rules created by the COVID-19 pandemic. Training modules included obstetric emergency skills and drills, adult and new-born life support, medicines management, identifying and managing sepsis, fetal monitoring and cardio tachograph (CTG) annual updates. The service also facilitates infant feeding training for midwives and support workers which include an annual update.

The service created a training compliance report for the trust board to evidence the requirements for CNST standard 8 compliance as of 1st of May 2021, which was valid up to the 1st July 2021. Records confirmed that 94% of consultants, 92% of obstetric doctors and 91% of anaesthetists had attended obstetric emergency training. Midwifery attendance was 96%.

For the same period 92.6% of doctors and 96% of midwives had received intrapartum monitoring training.

Safeguarding

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

The trust had children's and adult safeguarding policies which were aligned to national guidance and had been recently reviewed. Staff knew how to access safeguarding referral forms online and this included the contact details of the local safeguarding teams. There was an appointed named midwife for safeguarding.

Staff received safeguarding training specific for their role on how to recognise and report abuse. Clinical staff completed training on recognising and responding to women with mental health needs during their safeguarding training. Training also included a module on female genital mutilation.

In accordance to the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019), midwives and doctors were trained to level 3 safeguarding and attended annual updates.

Maternity

Healthcare assistants and administrative staff working in maternity were trained at level 2 safeguarding and records confirmed this.

Medical staff received training specific for their role on how to recognise and report abuse. Records confirmed that over 90% of doctors at Barnet Hospital had completed their training.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. The trust had created two teams of experienced midwives overseen by a lead consultant for perinatal mental health, who cared for vulnerable women. These included women who were severely depressed, had been victims of abuse, non-English speaking women, women with complex needs and women who were known substance abusers.

The team were responsible for making safeguarding referrals for all maternity staff and staff could refer women to the team at any point during their care. This team of specialist midwives would liaise with social care and attend case conferences, where they would have input into child protection and safeguarding planning.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

In line with the Multi-agency statutory guidance on female genital mutilation issued by the Department of Health and Social Care 2016. Staff informed us that women who presented for maternity care and had been subject to female genital mutilation (FGM) were risk assessed and were all routinely referred to the vulnerable caseloading team where applicable as per unit guidelines.

When safeguarding issues had been identified and reviewed the safeguarding lead could update patient electronic records with an alert marker which made sure all staff were aware of the risks associated with these vulnerable mothers and babies.

Staff followed the baby abduction policy and undertook baby abduction drills.

Cleanliness, infection control and hygiene

The maternity unit, controlled infection risk most of the time. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However, they did not always audit cleaning.

The trust infection control policy was updated during the COVID-19 pandemic and was in line with Public Health England's (PHE) COVID-19: infection prevention control guidance (2020). The trust employed an infection control team to oversee infection control risk assessments and training across the trust. The team were responsible for overseeing the provision and review of infection control policies and procedures; which included cleaning standards and implementing training packages across the trust.

Staff followed infection control standards which included the use of personal protective equipment (PPE). PPE was available in all areas, this included antibacterial hand gel, aprons and gloves, which staff wore during contact with women.

Maternity

Women and visitors had their temperature checked when arriving at the unit and everyone signed in so that people could be contacted in the event of a COVID-19 outbreak. Women were asked standardised COVID-19 questions prior to arrival and any woman who presented with any symptom would be isolated from other people.

Staff cleaned equipment after contact with a woman and labelled equipment to show when it was last cleaned.

Ward areas appeared clean and had suitable furnishings which were clean during the inspection. Staff we spoke with on the day advised us that monthly environmental audits had been increased to weekly. This had been as a result of three recent cases of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) on the ward.

Cleaning records were up to date in most areas, and all areas were visibly clean. We were told that the teams used a smart app with a standardised approach to check the environment and the equipment in all areas.

The Birth centre appeared clean and cleaning audits were completed weekly at the time of the inspection. Birth pools were cleaned after use, staff followed a decontamination procedure for birthing pools. However, staff did not record this anywhere on the birth centre and the infection prevention control team did not carry out spot checks or audits. This meant there was no assurance that the pools were completely free of bacteria. After the inspection the trust told us the use of water for labour and birth guideline has been updated to include updated guidance from the infection control committee regarding cleaning and auditing of pool.

During the inspection, we spoke with the trust's infection control team. The meeting was attended by the hospital's infection prevention control (IPC) lead and the microbiologist responsible for reviewing healthcare associated infections (HCAI) and any outbreaks reported by the microbiologist.

The IPC lead advised that there was not a formal record kept of pool cleaning. The IPC lead advised that they would consider implementing a sign off sheet in each pool room to ensure pool cleaning was documented in the future.

The trust had reported three MRSA infections. All three women had routine MRSA swabs before surgery which were clear. The women then had a caesarean section and the MRSA had been identified in their wounds. The findings had been reported to the local Clinical Commissioning Group (CCG) and the trust planned to meet with them to look at themes and share learning.

IPC advised they had completed deep cleaning in the key areas of the service user contacts and planned to swab key staff to rule out them as a potential carrier. The team had also identified lapses in hand hygiene by staff throughout the maternity unit and implemented supportive measures with increased hand hygiene and standard precaution audits (including PPE) to several times a week for six weeks. This was to make sure standards were maintained and practice embedded as it was felt that staff had been suffering from "cleaning fatigue".

To reduce the risk of further infection staff were advised that women's wound dressings should stay on for 48 hours. However, this was not being monitored. Data provided by the trust after the inspection showed that six women were re-admitted to the ward with the symptoms of wound infections between March and May 2021. The impact of this was mothers must revisit the hospital and new-born feeding routines were interrupted.

Environment and equipment

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

Maternity

The design of the environment followed national guidance. The department was airy and spacious, and rooms appeared clean and well stocked. The unit had the right equipment to help them safely care for women and babies. We inspected the labour ward, the ante/postnatal ward, the maternity day assessment unit (MDAU) and the triage area.

There was a 48 bedded maternity ward; three maternity day unit beds, five assessment chairs, and two rooms in triage. The delivery suite with 13 labour rooms, two obstetric theatres, with four recovery beds, two close observation beds, and neonatal unit on the same floor. The Birth centre, which was on a separate floor, contained: five birth rooms and three postnatal rooms and was designed as a low risk 'home from home' birthing environment. The obstetric theatres are located on labour ward and neonatal facilities are adjacent to the ward.

Equipment for the routine monitoring of women included: blood pressure monitoring equipment, thermometers and doppler fetal monitors and cardiotocograph (CTG) machines that monitor the fetal heart rate. Staff had antibacterial wipes available to clean the equipment after each point of woman care. Green 'I am Clean' stickers were available for equipment that was not in constant use.

Fridges that stored medication were checked daily to ensure the correct temperature was maintained and records confirmed this.

The unit had standardised check lists of emergency equipment. Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys and resuscitaires were well stocked and checked twice daily at the beginning of each shift. Staff used a check list to record that equipment was in working order and that single use items were in date. Once equipment was checked, the staff member had to date and sign the list. Any items found to be faulty were set aside and labelled, so that they were not used in error.

In the MDAU where women were referred to when they felt unwell, staff had access to an ultrasound machine, so they could assess women quickly. This was in good working order and the necessary calibration checks had been completed.

The Birth centre environment was airy, light, clean and well stocked, although equipment was stored out of sight to promote normality and provide a home from home environment. The lighting could be adjusted so that women could relax.

The unit had two resuscitaires, one was stored in a clinical room and the other in the corridor. These were checked twice daily, and we saw evidence of this. We asked staff how quickly they could access the equipment in the event of an emergency, and they explained that a risk assessment had been completed. To reduce risk rooms were stocked with portable resuscitators, which could be used in the event of an emergency, whilst support staff set up the large resuscitaires.

There were built in birth pools which had enough space around them for staff to care for women once in the pool. The trust had completed a task risk assessment for evacuation of the pool in the event of maternal collapse and new staff had simulated training to reinforce this. The unit had an 'evacuation of the pool' kit which was readily available. However, no records were kept of annual or ad-hoc training update sessions. One member of staff said she hadn't had an update for four years. This meant that community staff rotated into work on the Birth centre during their on-call, may not be fully competent in evacuating mothers from the pool. After the inspection the trust told us they have updated their skills drills evacuation protocol with an online video. This was delivered to all staff through the staff briefing and became part of the "better births" study day.

The service had suitable facilities to meet the needs of women's families. Although, as mentioned previously on the ward, bathrooms were shared.

Staff disposed of clinical waste safely. Controlled substances hazard to health (COSHH) was stored correctly. Bins were colour coded, and sharps bins were dated and available at the point of woman care.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. Although audits on wait times were not routinely completed.

A lead professional was identified to oversee the care of women at the point of booking for antenatal care. High risk women were allocated to a consultant team. The trust had lead consultants for diabetes, fetal medicines and perinatal mental health.

The service had several maternal care pathways. For example, a low risk community care; a vulnerable woman team overseen by a doctor for women who had severe mental health concerns or complex social history; obstetric led care for women with long term health conditions or previous traumatic birth and a team of continuity of care midwives for women wishing to have home birth or use the birth centre.

When women self-referred for care via the trust's public website, the webform included a series of questions that included the COVID-19 screening, the woman's age, pregnancy history, general health, ethnicity and what language the women spoke. These helped staff make decisions about who, when and where care should be provided and whether an interpreter was required during the booking appointment.

The trust provided service user safety information in 10 different languages. This was as a result of the Care Quality Commission's (CQC) last inspection of the trust's Royal Free Hospital site in October 2020, where problems were identified with language barriers and lack of safe and effective woman care information leaflets.

The midwives booking appointment was the first appointment for women. Women were asked a series of questions relating to their medical, social and emotional history. The midwives used a booking assessment tool in line with Antenatal Care; routine care for the healthy pregnancy woman National Institute of Health and Care Excellence (NICE) 2019). Risk assessments were reviewed at each appointment or after any incident of unplanned care.

When women attended their booking, they were risk assessed using a planned approach. Women had their self-referral form reviewed at the appointment and were asked a series of questions about their medical, emotional, social situations.

During the pandemic, many women were booked virtually to reduce transmission of the disease. The trust created a standard operating procedure (SOP) for reviewing women virtually. Staff had access to the most recent standard operating procedure 'New booking appointment and booking bloods process, including information provided to women' which had been updated in November 2020. The guideline was informative and included referral pathways for all women.

Maternity

Antenatal scans were offered throughout pregnancy, and growth was clearly plotted most of the time, and any risks were actioned by staff. The trust used GROW (Gestation Related Optimal Weight) software in order to produce customised growth charts for each pregnancy. At each appointment, staff plotted the fetal growth to ensure it was as expected for mother's gestation. Any differences in standard growth were referred to the hospital for extra scans and obstetric review.

NHS England developed a 'Saving Babies Lives' Care bundle (2016) which introduced five key elements to care. These were: reducing smoking in pregnancy, risk assessment prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR), raising awareness of reduced fetal movement (RFM), effective fetal monitoring during labour, and reducing preterm birth. The service had selected a consultant midwife to oversee all aspects of the saving babies lives care bundle. They were responsible for completing audits and feeding into staff training to ensure practice was embedded and women were safe.

If women had concerns about their pregnancy before birth or postnatally, they could call the maternity triage.

On arrival to Triage or MDAU, women were greeted in a timely way. Midwives completed an initial assessment using their colour coded risk rating system; red for high risk, amber for moderate risk and green for normal. This was to ensure that those at high risk were prioritised. For example, women who had contacted the unit with reduced fetal movements were sent directly to the MDAU and midwives ensured that a cardiotocograph (CTG) was commenced within 30 minutes. However, staff told us that delays in medical reviews during busy periods affected the timely management and treatment of women and that service managers did not audit wait times regularly.

The trust followed the physiological approach to interpreting CTG's known as FIGO and all staff have been trained to use and interpret CTG's using this model.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff asked women about their relevant obstetric/medical history, and completed a set of physical observations of pulse, blood pressure, temperature and respiratory rate and oxygen saturation levels when required. Staff used the Maternity Early Obstetric Warning Systems (MEOWS) charts which recorded electronically when women were assessed in triage, the MDAU and on the delivery suite. The electronic record generated a score based on the maternal observations. Higher scores would indicate that the woman required further interventions. Care plans were agreed with the women and documented on the patient record systems.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff used a standardised SBAR (Situation Background Assessment Recommendation) tool which referred to women's physical, psychological and emotional wellbeing. Digital patient records colour coded the SBAR headings so that staff could clearly document and communicate that mother's care plan.

When women were discharged from the hospital after an episode of care, they were given a discharge notification. When babies were born, birth notifications were sent electronically to the local authority. General Practitioners (GP's) and health visitors were notified, and women were discharged into the community setting.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Maternity

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance most of the time. Managers used the recognised workforce planning methodology (a method of assessing the needs of women for midwifery care throughout pregnancy), labour and the postnatal period in both hospital and community settings. The data provided makes it possible to calculate the required number of midwives to meet all of those needs in relation to defined standards and models of care and to local workforce planning needs, holiday and sickness. The current model included continuity of care and plotted local staffing requirements.

The Director of Midwifery advised us that in early in 2020 the midwifery workforce was understaffed by 16.9 full time midwives across both sites. A business case was submitted to secure additional funding. In July 2020, the trust funded 7.4 whole time equivalent midwifery staff and a further 5 were funded in January 2021. The final 4.4 whole time equivalent were due for funding in September 2020.

The maternity unit had lowered its vacancy rate over the last year. The most recent inclusive data for hospital-based staff confirmed that the current number of midwives employed at Barnet was 41.83 whole time equivalents (WTE) during the day with no shortfall. Night staffing was equalled 36.6 WTE, which meant there was a shortfall of 0.9%. However, some community midwifery teams had staff short falls. The Mill Hill team had a 20% shortfall and the Borehamwood team had a 7% shortfall in staffing.

Managers told us that the staff planning tool was due to be reviewed in September 2021. Currently the midwife to mother ratio within the unit was 1:28. The leadership team were aware of this and have created an escalation policy in the event of busy periods.

The number of midwives and healthcare assistants did not always match the planned numbers and when staff called in sick it was the ward that had their staffing numbers depleted to help cover delivery suite. Staff told us that working on the ward could be very challenging as most of the time staff were caring for nine women plus new-born babies. The acute needs of women varied; for example staff could be assigned to antenatal women who required extra monitoring and also care for women who had been admitted having an induction of labour and required interventions and finally postnatal women who had undergone surgery and their babies. In addition, midwives had to provide emotional and infant feeding support for these mothers and transitional care for babies who required interventions like regular intravenous antibiotics or phototherapy.

Delivery suite managers advised that managing staffing levels according to the needs of service was challenging as the service needs were continually changing. The current elective caesarean list, which was organised for a whole day on Monday's, Wednesday's and Friday's, added further pressure to staffing as one midwife was allocated to this. The delivery suite was managed by two band 7 midwives, one of who had supernumerary status and the other was shift co-ordinator for the day. Nine band 6 midwives worked on each shift covering 13 delivery rooms.

Managers advised us that they limited their use of agency staff and requested staff familiar with the service and records confirmed this. The trust had a bank staffing department which could draw on a pool of regular bank midwives to cover sickness and annual leave. Records confirmed that the total use of bank staff between December 2020 and May 2021 was 789 hrs for delivery suite and 797 hours for the Victoria ward with a total of 1586 which equates to 4 whole time equivalent posts. These hours would have been used to cover sickness and annual leave. The COVID-19 pandemic meant that some staff were off on long term sick shielding and others had to self-isolate due to their families or their own COVID-19 status.

Maternity

Managers made sure all bank and agency staff had a full induction and understood the service. This was because most staff had worked within the Royal Free London and the hospital also used the national NHS professionals bank staffing system who make sure all staff received inductions and mandatory training.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. Records confirmed that the current budget for consultants was 15.3 whole time equivalents, although there was currently a shortfall of 0.6 whole time equivalents.

The hospital consultant cover for the unit was on site for 98 hours a week between 8am and 11pm Monday to Friday. Saturday and Sunday on site cover was provided from 8am to 8 pm. This was in line with The Future Workforce in Obstetrics and Gynaecology report Royal College of Obstetricians and Gynaecology (RCOG (2009) which recommends obstetric consultant staffing for units with over 2500 – 6000 births: 40 hours cover and units of over 6000 birth: 60 hours.

Workforce planning was reviewed by the clinical director and the medical governance team who followed the RCOG Future workforce recommendations and regularly reviewed birth rate data for the trust.

Anaesthetists were available immediately 24/7 and included several consultant sessions a week and extra for elective Caesarean Sections on Monday's, Wednesday's and Friday's.

Consultants were present on the labour ward throughout the day and attended morning handovers.

Morning handover was attended by doctors, the midwife co-ordinator of the shift and the paediatric lead for the day. Daily cross-site huddles were attended by medics, midwives and paediatric staff at 11am via online meeting platform. During these calls, the capacity of the unit was discussed, as well as any staffing issues and practice updates.

The trust recognised that it had been difficult to recruit trainees and junior clinical fellows into the unit. The junior doctors we spoke with said they had been supported from the day they started in the service. The current on call system was two registrars and two SHO's who covered Maternity and gynaecology during the week and one on call at the weekend. Staff told us that there were times at the weekend when they felt rushed and unable to take breaks.

The service had consultant leads for perinatal mental health, diabetes, fetal medicine, and a lead for fetal monitoring during labour.

Managers could access locums when they needed additional medical staff. The service had low use of locum staff, and the locums that were recruited by the trust were given a full induction.

The service had a good skill mix of medical staff on each shift most of the time and records confirmed this.

The service always had a consultant on call during evenings and weekends who worked remotely from 11pm to 8am weekdays and 8pm to 8am on Saturday and Sunday. Although, consultants could not access all patient records remotely or review cardiotocographs remotely at the time of the inspection. Staff told us that consultants could attend the unit within half hour of being called when required.

Maternity

Records

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

Women's maternity records were stored on a nationally recognised digital patient record system. Women records were a combination of paper and digital records, the woman's booking risk assessment was input via the digital system but women were given a printout so they could keep this with them if they travelled out of area.

Women had a digital patient record app and were able to access their care via this; information included risk assessments and pregnancy screening results.

Women's notes were comprehensive, and all staff could access them easily most of the time. Staff had access to the digital patient care records via individual password protected log in details. Most community midwives could access the digital care records within the community, although, if there were connection issues, they would document on paper then upload the information at the end of their shift.

Throughout the unit, we observed staff completing observations and risk assessments on paper and directly into the digital patient record system. There were computers in all parts of the maternity and the trust had provided mobile computers that could be moved around to areas where computers were not available.

Two pre-printed logs were kept on the midwives' desk in a private office of all calls taken for antenatal and postnatal enquiries. Prompts were printed in the logs, which included; dates and times of call, woman's details and her query. This information was then inputted onto the electronic system. This process had been introduced as a result of a serious incident to make sure that records could be accessed in the event of a systems breakdown or for investigation purposes.

When women transferred to a new team there were no delays in staff accessing their digital care records. Referrals to specialist services were documented on the electronic patient records. However, some records were paper only and detailed medical records which contained the mother's medical history were not available at booking in appointments. Although these records could be ordered by the midwives or doctors caring for women after the appointment, it meant vital medical, psychological or social history may not been known at the first point of care, there may be missed opportunities to explore complex history's with some women.

Manual patient care records were stored securely. The information in paper care records was limited to the current episodes of care. There were times when digital systems were difficult to access, we highlighted this at our previous inspection at the Royal Free Hospital and the trust had systems in place to reduce risks. Paper records were used as a support to the digital systems and the service was in the processes of moving all records to a digital system.

Baby records were currently a combination of paper and electronic records throughout the maternity unit. The Children's and Young People's service did have digital systems but at the time of reporting these were not currently married up with the maternity unit.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Women's medication prescribing was completed online via the trust's prescribing aspect of the digital patient records system. However, babies prescribing was still completed onto a handwritten drugs chart, which followed the baby from the neonatal unit to maternity when required.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Our recent inspection of the Royal Free Hospital site had identified issues relating to out of date medication. The trust had updated staff on the importance of checking dates of stock. A daily pharmacist was on call for the unit to provide medication advise and support for staff. Pharmacy completed weekly stock checks.

Controlled medication was stored in a locked cabinet in a key coded clinical room. Staff completed twice daily controlled medication checks at the beginning of each shift. The records were dated and signed by two midwives.

Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines. During the inspection, we reviewed 14 sets of patient records which confirmed that electronic prescribing had been completed correctly.

Staff followed current national practice to check women had the correct medicines. Medication management audits were completed weekly within the unit to ensure that staff were correctly prescribing and dispensing women's medication. Staff completed annual medication management competency training and testing.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. These were highlighted on the digital patient records.

Incidents

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

The trust Deputy Director of patient safety and risk had recently completed a review of and amended the incident policy and the risk management policy following a recent CQC inspection.

There was evidence that changes had been made as a result of feedback. The trust had submitted a report update of the combined actions in April 2021 which confirmed they had oversight of the recommendations and had implemented changes.

This was implemented in March 2021 and staff were updated via the trust's 'risky business' staff newsletter and daily safety huddles. To make sure that the changes were embedded into practice, the trust completed audits for serious incidents involving mothers and babies that maybe referred to the Healthcare Safety Investigation Branch (HSIB).

The service had made other improvements to its incident reporting and learning since the last CQC inspection. Actions resulted in the effective monitoring and scrutiny of the implementation of serious incidents recommendations and lessons learnt. Also, the service reduced the number of open and overdue serious incident actions.

Staff knew what incidents to report and how to report them. Staff gave us examples of what to report, and understood the importance of reporting incidents, to help improve care.

Maternity

Staff raised concerns about women care and reported incidents and near misses in line with trust policy. However, some staff felt that continually reporting short staffing hadn't improved the situation, so they had stopped reporting this. At the end of our inspection, we fed this back to the director of midwifery who informed us she would remind staff of the importance of reporting all incidents.

Managers shared learning about never events with their staff and across the trust. Learning was trust wide and staff now received feedback for the incidents they reported via the Risky Business newsletter and other information was shared via the Audit and guideline newsletter. The service had also increased attendance at safety huddles and remote staff meetings were now well attended because staff could now access them from home.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations when suitable. The CQC reviews incident data submitted monthly by the trust to ensure these were graded correctly in accordance with the level of harm. During the inspection, we interviewed key staff who were responsible for reviewing and grading incidents. They were able to talk through the process for reviewing, investigating and grading maternity incidents.

The trust had a multi-professional approach to reviewing incidents. Minutes of risk meetings confirmed that doctors, midwives and paediatricians could be involved in reviewing incidents. The current system was robust and went through several levels of quality control to make sure that gaps in care and any themes were identified and reported to the Deputy Director for patients' safety and risk.

Following the last CQC inspection, the trust had made improvements to its compliance with the Duty of Candour regulations. We found staff understood the Duty of Candour requirements. They were open and transparent and gave women and families a full explanation when things went wrong. The trust had amended the Duty of Candour policy in March 2021 so that it included an escalation and recommendation in the event of noncompliance. The Serious Incidents Progress standard operating procedure was amended to include an audit of completed Duty of Candour letters. The letters now included a written apology to parents and families and the contact details of the patient safety and risk managers.

The trust now reported all serious incidents related to intrapartum stillbirth, early neonatal deaths and severe brain injury diagnosed in the first seven days of life to the Healthcare safety Investigation Branch (HSIB). The trust had implemented a process for escalating non-compliance of the recommendations via the women's and children's governance and trust governance reporting

The Barnet site had no 'never' events in the 12 months prior to our inspection. Although, staff recalled a never event that had occurred at the Royal Free Hospital, and what actions had been taken to make sure this type of incident did not reoccur.

Is the service effective?

Inspected but not rated

Competent staff

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

Maternity

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The service practice development midwife (PDM) and a professional midwifery advocate (PMA), monitored midwifery training and supported midwives to continue their professional development.

Managers gave all new staff a full induction tailored to their role before they started work. The PDM was responsible for reviewing, implementing and monitoring training for midwives and support workers within the service.

The clinical educators supported the learning and development needs of staff. Newley qualified staff had a nine month in house preceptorship which followed the Capital Midwife program. This was developed in response to the need to respond to challenges that included staff shortages, increased workloads and retention of staff and policy changes. The trust recently won the 'capital midwife quality mark' for delivering a program that continued to support and develop new midwives' knowledge and skills.

Managers made sure staff had an annual appraisal this was monitored and arranged in advance and records confirmed that 90% of staff had completed this year. The PMA follows the A-EQUIP model for the supervision of midwives in practice. A-EQUIP, an acronym for advocating for education and quality improvement. The model supports a continuous improvement process, for preparing for appraisals and revalidation to the Nursing and Midwifery Council (NMC). They arrange group sessions for midwives to provide mandatory updates they work alongside the governance and risk team and help midwifery staff to reflect on serious incidents and near misses.

Multi-professional training was a standard part of professionals' continuous professional development (CPD), both in routine situations and in emergencies.

Consultants supported obstetric doctors to develop through yearly, constructive appraisals of their work. Doctors interviewed during the inspection felt supported and were given opportunities to develop their skills and knowledge.

Consultants supported medical staff to develop through regular, constructive clinical supervision of their work. Managers made sure staff received any specialist training for their role. Obstetric doctors attended multi-professional emergency skills and drills and the service provided weekly ad-hoc training on a Friday. On the day of our inspection, obstetricians held a session on instrumental deliveries which was well attended.

Locum doctors were provided with an induction and were given a competency document to complete which was signed off by the consultant supervising them

Managers identified poor staff performance promptly and supported staff to improve. We were given an example of this by the PMA. Poor performance was highlighted through incident reviewing and staff had been identified as requiring support.

Healthcare assistants were employed at band 2 and band 3. Training included postnatal newborn bloodspot screening, how to take bloods, use of the electronic patient records and more recently vaccinator course training.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

Maternity

The service used monitoring results well to improve safety. Maternity measured metrics within the maternity dashboard which was based on the Maternity Dashboard Clinical Performance and Governance Scorecard standards Royal College of Obstetricians and Gynaecologist (RCOG (2008). Better Births (2016) recommended that a nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services. The dashboard helps clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purpose of identifying areas that may need local clinical quality improvement.

Dashboard data for the period of January 2021 to March 2021 was compared to national data for the same period. The 1804 women were booked for care in this period and 100% of those received a personalised care plan. In the same period, 1268 babies were born and one neonatal death within 28 days, which was lower than the national average of 2.8 per 1,000. National data for caesarean section in the same period was between 28-30%, at Barnet hospital unit this was 43%. Caesarean sections are a lifesaving intervention. Increased caesarean rates can be caused by higher instances of poor health, women who have had previous caesarean sections.

The service contributed to the national audit program for maternity units. Audits were assigned project leaders and used planned methodology. Data provided by the trust confirmed that the service had a good oversight of all ongoing audits which were reviewed and updated on a regular basis.

The service continually monitored safety performance. Above average activity on the dashboard were highlighted in red and were reviewed at the trust's maternity risk management meeting. However, the maternity scorecard data was not displayed on wards for staff and women to see.

The trust reported to the MBRACE-UK Maternal, Newborn and Infant clinical outcome review programme, which aims to provide robust national data to support the delivery of safe, high quality, patient centred maternal, newborn and infant health services. This was achieved because trusts report all maternal and perinatal deaths including fetal losses between 22-23 weeks, stillbirths and neonatal death. New recommendations included: maternity units have access to epilepsy teams, established pathways for rapid stroke diagnosis and provide specialist multi-professional care for bariatric surgery.

The service submitted data to the maternity services data set to the required standard and records confirmed this.

The service offered continuity of care from November 2020 to April 2021 to 35% of women who referred for care with the trust; 28% were women from black, Asian and minority ethnic backgrounds. The revised CNST standards requires maternity services to have an action plan in place to demonstrate continued working towards placing 35% on a continuity of care pathway, prioritising women from the most vulnerable groups and taking into account the increased risks facing women from black, Asian and minority ethnic groups (NHS Resolution 2021).

Records for January 2021 to March 21 confirmed that 85% of staff used the SBAR handover process and took the appropriate actions. The audit confirmed that 95% of staff had completed MEOWS observations and 100% of staff using MEOWS took the appropriate actions.

A CTG audit completed in February 2021 of 20 patient records highlighted that hourly 'fresh eyes' were only completed for 90%, although concerns were escalated correctly in all cases.

Managers shared and made sure staff understood information from the audits. The reason for non-compliance was clearly documented and the trust continues to monitor this and update staff via emails and their 'Risky Business' newsletter.

Staff knew about and dealt with any specific risk issues reporting alerts for maternal sepsis, pre-eclampsia, and various other medical and pregnancy related conditions.

The service made sure women were given information, advice and support to feed their babies. The trust had received a UNICEF stage 3 award. Audits confirmed that staff were performing well and understood the key principles of supporting breastfeeding.

Data reviewed by the CQC indicated the caesarean section rate was higher than the national average and at the Barnet site was approximately 27% of births during February, March, and April 2021. In comparison, the expected national rate was 19-20% over the same period. The trust had developed a plan to reduce its rate in the future.

Unexpected transfers to intensive care or neonatal intensive care were reviewed for themes and action plans put in place. Managers worked with the neonatal unit to review the data. Weekly reviews were completed by delivery suite managers and fed into the Avoiding Term Admissions to Neonatal Units (ATAIN) working group. Records confirmed that the service was monitoring the data effectively and benchmarked against national performance. The current rate of babies who had needed transfer to the neonatal unit was 5% for the period April 2020 to Jan 2021, which was a 1% decrease on the previous year.

The service monitored antenatal screening key performance indicators. One screening midwife was responsible for gathering data in line with the NHS Infectious Diseases in Pregnancy Screening Programme and NHS Sickle Cell and Thalassaemia Screening Programme. If performance fell below the expected 95%, investigations were completed to ensure training was embedded, staff had the appropriate equipment and women had been advised of the risks and benefits.

The trust checked Women's re-admission rates for wound infections after surgery. Data for March 2021 – June 2021 confirmed there had been six re-admissions for wound site infections.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. Managers made sure meetings were recorded and information shared to improve communication and attendance.

Twice daily ward handovers were done on the delivery suite and the maternity ward at shift changes. Handover information was recorded on a printed handover sheet and the leads for the handover were clearly identified on the information. Women were holistically assessed and their care plans and progress during childbirth was discussed. Handover boards were updated clearly with key information to help managers plan care and escalate concerns.

Midwives, working on delivery suite completed a detailed handover for the women they had been allocated to at the start and end of shifts, using SBAR (Situation Background Assessment Review)

Maternity

Daily cross-site safety huddles took place at 11am. A huddle was a short, focussed briefing that brings together key staff to discuss access flow and identify any safety issues. NHS Improvement: Implementing huddles and handovers — a framework for practice in maternity units (25 March 2019) recommends that key staff were made available to attend. The services huddles included updates on women acuity, bed availability, and the type of admissions. This was an opportunity to review any safety issues or serious incidents. Key staff were meant to attend these meetings, they included the delivery suite obstetric consultant, the delivery suite co-ordinator, the maternity bleep holder, the neonatal charge nurse and the neonatal consultant. However, records of huddles confirmed that delivery suite consultants and co-ordinators at the Barnet site rarely attended, which meant they were not involved with planning the day's activity throughout the unit.

The service had created combined clinics for women suffering from diabetes and women who had complex mental health illnesses. Midwives and doctors would work together and worked closely with the trust's diabetic lead and mental health liaison team. A team of midwives was clearly identified to care for women with complex mental health and complex social histories. Their role was to liaise with social care, general practitioners, family nurse partnership teams and any other services that the women required.

Staff worked closely with the neonatal doctors and nurses and MDT meetings were attended by staff from both units. Unwell babies were reviewed by a multi-professional team care was reviewed regularly and concerns escalated. Incidents were fed back to maternity when appropriate and incidents were investigated by both services when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

To ensure patient consent forms were completed correctly the service implemented updated training and carried out monthly spot checks.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. The trust created a guideline for referral to a multi-professional team available to support women with complex mental health illnesses. This was in line with several current national guidelines and reports. A multi-professional Complex Women's Team offered enhanced individualised Continuity of Carer (CoC) care to vulnerable families, in line with current policy recommendations (NHS Long-Term plan, 2019). The CoC model of care was designed to ensure safer, more personalised care based on the consistency of the midwife throughout the antenatal, intrapartum and postnatal period and through a relationship of mutual trust between the woman and the midwife.

Staff completed risk assessments for women thought to be at risk of suicide or self-harm. In line with Antenatal and postnatal mental health: clinical management and service guidance NICE (2014).

The service had 24-hour access to mental health liaison and specialist mental health support and a team of specialist midwives, and a lead consultant were responsible for caring for women with severe mental health illness and provided continuity of care. They held joint clinics and staff used a multi-disciplinary approach to care and liaised with local perinatal mental health teams and GP services.

Maternity

Staff followed a referral process to the teams once a concern mental health risk assessment had highlighted women who needed continuity of care. Women could be referred by community midwives, obstetricians or multi-professional agencies.

When women could not give consent, staff made decisions in their best interest, considering women's wishes, culture and traditions.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Once staff gained consent from the women, a named midwife was offered to these women based on their geographical area. All women were assigned the named consultant linked to the complex women's team.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment (only used where young people are treated on a ward).

Is the service well-led?

Inspected but not rated

Leadership

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

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

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

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

Trust maternity and neonatal champions monitored progress and improvement within the service. There was an effective trust board oversight of performance. The trust submitted the Ockenden assessment tool to NHSE/I regional team on 15 February 2021 (a tool to support providers to assess their current position against the seven immediate and

essential actions in the Ockenden Report and provide assurance of effective implementation). Following the self-assessment, regional teams would assess the outputs of the self-assessment and would work with providers to understand where the gaps were and provide additional support where this was needed. The assessment would take place between 22 February and 18 March 2021.

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

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

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

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

Vision and strategy

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

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

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

Governance

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

The service had made improvements to their governance processes since the last inspection at the trust in October 2020. Staff had developed a maternity risk management policy which identified key individuals, responsibilities, governance structures up to board level, and dissemination channels. The service also received greater support from the

trust leadership team, including board members, to deliver this work. There was a better multidisciplinary approach to governance with all staff invited to attend the monthly governance risk meeting. The service introduced a rapid review template which clearly identified immediate actions taken by the service, although this was not always used for all serious incidents.

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

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

The care group made sure that this was a main priority for maternity services. Records confirmed that leaders reviewed the Perinatal Mortality Report, The Saving Babies Lives care bundle, Avoiding Term admissions to Neonatal Units (ATIAN), maternity services data sets, HSIB and maternity clinical dashboards were amongst 15 aspects of governance that were being clearly monitored.

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

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

However, leaders told us that there were current barriers to introducing new styles of practice. Business plans were submitted, and requests for the introduction of new medications or equipment was reviewed and then must go through procurement and finance departments. Changes can take time, which means new technologies and medications that have been shown to improve care cannot always be introduced when needed. One example was the introduction of the updated instrumental delivery guideline which was delayed due to the workload of the antimicrobial stewardship team.

Culture

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

The board wanted to promote a culture of learning and continuous improvement to quality and outcomes from their services. There was a trust wide annual 'star award' for each care group. Maternity staff awards were led by the professional midwifery advocate, staff were encouraged to nominate colleagues who had gone above and beyond. The

nominations were counted monthly and those staff who won were awarded a gift voucher. However, the most recent staff survey only received a 17% response. There were no current plans to increase staff awareness of the survey or give staff protected time to complete the survey. Poor response levels do not reflect the feelings of all staff working in the trust.

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

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

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

Midwives and doctors worked well together, there was an obvious culture of mutual respect. Staff we spoke to felt the unit was friendly and open, and staff looked forward to coming to work most of the time.

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

Most staff we interviewed throughout the service were positive. Staff felt, respected, valued and supported most of the time. Staff gave examples of managers attending the unit during busy night shifts to provide support. However, some staff felt that the ward was understaffed, and care disorganised, which meant they could not take their breaks. They had raised their concerns with managers, and although these had been acknowledged, nothing had been done to improve staffing levels or service configuration on the ward. The impact of this was that staff fell ill which resulted in sick absence and were rushed when providing care. Records confirmed that 15% of complaints were about the attitudes of staff. Following the inspection, the trust confirmed that the maternity services submitted a business case to secure additional funding. In July 2020, the trust funded 7.4 whole time equivalent midwifery staff and a further 5 were funded in January 2021. The final 4.4 whole time equivalent were due for funding in September 2021.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

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

Senior staff improved how they managed risks, issues and performance and aimed to create a learning culture. Since the last inspection, the service had developed policies related to risk management, incident and near miss reporting and learning. Since January 2021 all staff were invited to maternity risk management meetings which were cross-site. Attendance at the meetings was good (between 30-45 staff members), with different staff groups at different levels joining the call. During the meeting staff discussed departmental risks, outcomes, updates to policies, audits, incidents

and learnings among others. Also, the service invited all staff to monthly maternity safety briefing calls. These were organised a few times a month, at different times to ensure all staff could attend. The calls focused on mothers' and babies' safety, learnings from incidents, best practice and changes to practices. We saw examples of learning from incidents being timely shared with staff and discussed at different forums to reiterate the message and ensure it reached all staff.

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

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

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

Managing information

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

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

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

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

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

Engagement

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

Although managers gave us examples of when they engaged with women or staff, and processes were changed as a result of feedback, we heard example where engagement was not always followed through.

Although there was an improvement in the working relationship between the MVP and the trust and we heard some good examples of collaboration work, this relationship was still developing. Sometimes the MVP were only involved in coproduction work once work was underway or already completed.

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

To increase the service user feedback response rates, the service's 'Your feedback matters' posters were visible in the clinical areas which demonstrated examples where women complimented the service, however there were no examples of how the service acted on complaints.

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

The most recent 'Ask the Midwife' session was directed at Romanian non-English speaking women. Maternity managers arranged an interpreter who was able to translate questions to staff regarding their care. The women had identified issues in relation to their understanding of accessing free interpreters during their routine antenatal appointments, as they did not all know they were entitled to this aspect of care. This session had highlighted to the care group some of the differences in advice given to women. Staff at the trust and the MVP recognised how valuable this session had been to build a picture of non-English speaking women's barriers to care.

Engagement with women had improved, but there was some way to go. The pandemic had meant many women felt isolated and, although the trust was working had to improve this, there was still some way to go.

Learning, continuous improvement and innovation

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

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

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

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

Maternity

Areas for improvement

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

Action the service SHOULD take to improve:

- The trust should ensure that managers make sure they monitor cleaning of all areas and the birthing pools all the time and complete weekly audits to ensure that women and babies are protected from infection.
- The trust should ensure that it routinely monitors wait times in the maternity day care unit (MDAU) and reviews the results and adjusts staffing levels to ensure women are seen in a timely way.
- The trust should ensure that delivery suite consultants and midwifery shift co-ordinators should always attend daily cross-site safety huddles.
- The trust should consider their population's profile, health deprivation, disability and the broader needs of their culturally diverse communities when planning the service.
- The trust should ensure there is an active non-executive board-level maternity safety champion.
- The trust should make sure they initiate changes to services based on feedback received from women and implement the changes with the support of the MVP.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an experienced midwife and an experienced obstetrician. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.