St George's University Hospitals NHS Foundation Trust

St George's Hospital (Tooting)

Inspection report

Blackshaw Road
Tooting
London
SW17 0QT
Tel: 02086721255
www.stgeorges.nhs.uk

Date of inspection visit: 22 March 2023 to 23 March 2023
Date of publication: 16/08/2023

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 St George's Hospital (Tooting)

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the overall ratings of that location. From page 3 the ratings and information relate to maternity services based at St George's University Hospital, Tooting.

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

We last carried out a comprehensive inspection of the maternity and gynaecology service in 2016. The service was judged to be good overall in 2016. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings.

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.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

- Our ratings of the maternity service did not change the ratings for the hospital location overall. The location remains rated as requires improvement overall.
- We rated maternity services safe as inadequate and maternity services well-led as inadequate, and maternity services overall as inadequate.

How we carried out the inspection

We inspected the service using a site visit where we observed care on the wards, spoke with staff, managers, and service users, and attended meetings. We interviewed leaders and members of the executive team remotely after the site visit. We looked at online feedback from staff and service users submitted via the CQC enquiries process. The service submitted data and evidence of their performance during the factual accuracy process which was analysed and reviewed for use in the report.

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

Maternity services at St George's University Hospital, include antenatal, intrapartum (care during labour and birth) and postnatal care. St George's University Hospitals NHS Foundation Trust formed a Hospital Group together with Epsom and St Helier University Hospitals NHS Trust in 2022. The Hospital Group is called St George's, Epsom and St Helier University Hospitals Health Group (GESH).

The maternity unit included a consultant-led labour ward, maternity triage, a day assessment unit, a fetal medicine unit, and wards for antenatal and postnatal care. The alongside midwifery-led birth centre provided intrapartum care for women and birthing people who met the criteria and were assessed to have lower risk pregnancies. The birth centre had 4 birthing rooms, 2 of which had a birth pool. Between April 2021 and March 2022 there were 4560 babies born at St George's University Hospital.

This is our first rating of maternity services without gynaecology services at St George's University Hospital. We rated it as inadequate because:

- There were not enough staff to keep women, birthing people, and babies safe. Staff were not supported to complete mandatory training and did not have appraisals. Infection prevention and control measures were not effectively carried out and during the inspection several areas were found dirty and poorly maintained. Estates' response to maintenance issues was slow and the environment was in a state of disrepair. Medicines were not always stored safely. Staff did not risk assess women and there was no prioritisation tool to support staff in quickly assessing those in most clinical need. Staff review of fetal monitoring in labour was not safe. Incidents were managed; however, severity of incidents was frequently downgraded, and harm-ratings were inappropriately assessed which limited opportunity for learning and improvement.
- There was an improving but poor culture within the staff groups. Service leaders and safety champions were not visible to staff. Safety champions were not embedded in the service and had limited, superficial knowledge of the service. Support for the service from the executive level was poor, and executive leaders failed to recognise the severity of issues faced within maternity.
- Workforce data at a trust level showed disparity between the experiences of staff ethnic minority groups and White staff. This was reflected in feedback from staff we spoke to whilst on inspection. Staff told us they were undervalued and not supported by managers. The service did not take swift action to mitigate serious risks of staffing levels and estates management within maternity services. Implementation of improvement action plans was slow or not evident. Governance processes were not effective.

However:

- Staff reported close working relationships within small teams and the wider multi-disciplinary team. Staff expressed real concern for safety and wished to do their best for women and birthing people accessing the service. Records were mostly well maintained overall, and medicines were administered safely. Staff reported incidents and estates problems appropriately. Women and birthing people generally had high levels of satisfaction with the service and the service scored highly in the CQC maternity survey. There was a high level of consultant presence on the delivery suite.

Maternity

- The Director of Midwifery had been in post for approximately 2 and a half years; culture was improving, and several areas of improvement had been made. Improvements included the introduction of a maternity helpline, enrolment on the Capital Midwife Scheme (a framework and quality mark used by maternity units across London to standardise and quality-assure preceptorships, including racial equality), and the development of a comprehensive strategy for maternity services.

Following our inspection, we served a warning notice asking the trust to make significant improvements in the timely and effective triage of women and birthing people, timely response and maintenance of structural or equipment issues, safe levels of staffing, and governance and oversight of the service. The service was required to submit an action plan, and we will continue to monitor progress in relation to this.

Is the service safe?

Inadequate

This was our first rating of maternity services without gynaecology services at St George's University Hospital. We rated safe as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Midwifery staff were not always up to date with their mandatory training. Compliance figures provided by the service showed that midwifery staff training met the trust target of 90% in 3 out of 11 modules, with figures ranging between 65% and 89% training completed in the 8 non-compliant modules. During the factual accuracy process, the service told us there was a new compliance rate of 85%, and this meant staff were compliant in 5 out of 11 modules.

Medical staff did not always receive or keep up to date with their mandatory training. Compliance data showed enough consultant doctors had completed training in 16 out of 25 (64%) modules. Training compliance for consultants was below the trust target in resuscitation, disability awareness, and safeguarding children, with rates of 52%-68%. During the factual accuracy process the service told us that the low compliance in mandatory disability awareness training reflected that this training programme was launched in September 2022, and the completion rates reflected that this was a recent addition to the mandatory training programme.

The service did not adequately support junior doctors to complete mandatory training. Data submitted by the service showed that compliance levels met the trust target in 7 out of 25 modules (28%).

Training days were regularly postponed to free up staff to work clinically on days when there were staff shortages. Training days were then rescheduled. The impact of this was staff not being up to date in their training and there was a risk that staff provided inappropriate care. The service ran annual midwifery update days separate to 'practical obstetric multi-professional training' (PROMPT) and mandatory training, and these update days were paused first. Staff told us update days were paused until September 2023. During the factual accuracy process, the service told us the annual update day was planned for September 2023 but rescheduled to January 2024 to ensure that new staff joining the service in October 2023 could benefit from the training.

Maternity

The mandatory training was comprehensive and met the needs of women and staff when it was completed. Midwives completed specific cardiotocograph (CTG) training and compliance rates in February 2023 were 90% which met the required training performance target for the maternity services incentive scheme (CNST).

Midwifery staff completed pool evacuation training and compliance was 94% which was above the trust target of 90%. Safeguarding training was provided and 94% of midwives had completed it. Medical staff completed fetal monitoring training and records showed that 20 out of 23 (87%) junior medical staff had completed the training in the last year.

The service provided Practical Obstetric Multi-Professional Training (PROMPT) for emergency situations, which 90%-97% of midwives and obstetric doctors had completed. Compliance rates for maternity support workers and anaesthetists were slightly lower at 87%, which was below the trust target of 90%.

Staff completed newborn life support training and overall compliance between staff groups was 94% which was above the trust target of 90%.

Senior midwives completed human factors training.

The birth centre was equipped with wall-mounted resuscitaires however, these were not in use pending adequate staff training levels of 80%. At the time of inspection approximately 60% of staff were trained in the use of wall-mounted resuscitaires. There were other resuscitaires available for use and staff were trained to use them.

Safeguarding

There was no safeguarding policy specific to maternity services. However, 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.

There was no maternity specific safeguarding policy and staff referred to the trust safeguarding adults' safeguarding policy, which was not always relevant. Staff utilised the safeguarding team for advice however, staff told us they were not always available. During the factual accuracy process, managers told us safeguarding advice and support was available 24 hours for maternity services. In-hours support was provided by the safeguarding team and out of hours support was provided by the maternity services manager on-call. The absence of guidance and specific policy impacted on staff confidence with care planning. The impact of this was potential delay, and miscommunication to women and birthing people who had safeguarding needs.

There was a baby abduction policy and a simulation drill had been carried out in November 2022 which identified areas for improvement. Service leaders said there was an action plan to complete, and work was ongoing at the time of inspection.

Staff did not always receive training specific for their role on how to recognise and report abuse. This has been commented on in the mandatory training section.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). The service was aware of how best to work with parents with learning disabilities for positive outcomes and involved the multi-disciplinary team in any care planning. The service used a 'maternity passport' for women and birthing people with learning disabilities to communicate their needs and wishes effectively.

Maternity

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. Managers collected data on women, birthing people, and their families at risk of safeguarding concerns.

There was a community team that cared for women and families with safeguarding concerns. The team worked collaboratively with local authority teams to deliver wrap-around care for women, and they were overseen by the Deputy Director of Midwifery.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

Premises and equipment were not always visibly clean. Staff used equipment and control measures to protect women, themselves and others from infection.

During the inspection we found a ripped mattress that was in use. This was an infection risk. We escalated to staff during the inspection who condemned the mattress and reported it for removal and replacement. We found clinical areas that were dirty. This was escalated to staff for cleaning.

Managers monitored hospital acquired infections such as *C. difficile* and MRSA/MSSA. There had been one recorded case of MSSA at the service in February 2023.

Cleaning and decontamination scores were monitored monthly by managers. Scores for February 2023 were 98.9% overall, this was below the trust target of 100%.

Staff followed instructions for cleaning birthing pools and recorded daily flushing to minimise the risk of *Legionella*.

Staff were not aware of any spill kits that may be kept on the unit to safely clean spilled liquids, however staff said they would clean spills appropriately.

Staff followed infection control principles including the use of personal protective equipment (PPE). Between December 2022 and February 2023 hand hygiene audits met the trust target and scored above 97% each month.

Staff sometimes cleaned equipment after contact with women and sometimes labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance, and use of facilities, premises, and equipment did not keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Staff mostly carried out daily safety checks of specialist equipment. During the inspection we found some instances when daily checks had not been completed, and undated data submitted by the service showed that the resuscitation and emergency trolleys were checked 74%-81% of the time, which was below the trust target of 90%. We found equipment missing from emergency trolleys during the inspection and this was escalated to staff and rectified immediately.

Maternity

Equipment was not maintained safely. We found broken equipment and portable appliance testing (PAT) was not completed in a timely way, including for resuscitaires (machines used to support babies born in poor condition or not breathing).

The service had aging facilities in a state of disrepair that did not meet the needs of women, birthing people, and their families. Birthing rooms did not have ensuite facilities and this was not in line with current national recommendations. There were not enough toilets and bathrooms on the unit, postnatal women and birthing people had to mobilise some distance to use the bathroom even following surgery or if unwell. During the inspection, we found clinical rooms that had not been adequately repurposed for use, with broken tiles and broken fixtures that presented a risk. Several areas throughout the unit had peeling paint and dirty walls.

The maternity unit was in a hospital block built during the 1970s and the design of the environment did not follow current national guidance. The unit was spread over various floors of the building. There was a risk assessment for transferring women and birthing people in labour from the birth centre to the delivery suite. Staff told us that this worked well, and priority passes for lifts ensured this was managed in a time-appropriate way. However, lifts were situated in busy, public corridors which did not maintain the privacy and dignity of women and birthing people being transferred. The service had acted on feedback and moved the early pregnancy unit out of the antenatal clinic area, which was in line with current national recommendations.

There were two obstetric theatres, and staff said capacity was challenging for the number of theatre cases at the hospital. Theatre rooms were small, and it was not easy for staff to navigate around them.

The maternity unit was accessed via locked doors with an electronic access system for maternity staff only. However, the security system was not always effective and there were security breaches noted by the service. A baby abduction drill had taken place in November 2022 and a number of improvements were identified. Work to implement these had not been completed at the time of inspection. During the inspection, a new access system was being installed however the service had not taken all possible precautions to ensure the unit was secure. We spoke to the trust on the day of inspection, and they told us following the inspection that security measures had been put in place and would be monitored.

The maternity unit in general had poor levels of tidiness and we found cluttered environments, obstructed emergency equipment and doorways, and equipment stored in inappropriate places such as corridors and staff rooms. We asked staff to rectify this wherever possible however, there was a lack of adequate clinical and storage space for staff to be able to work safely. We found a fridge used in a corridor without locks or safety measures, this was rectified by staff on the day and a new locking fridge was ordered.

The service did not have use of transcutaneous bilirubinometers (TcB), (devices to measure jaundice levels in babies) in the community to minimise invasive procedures on babies and reduce readmission to hospital. However, the service did have one TcB for use on the postnatal ward. There was a paediatric ambulatory service that community midwifery services referred babies to directly for any concerns such as jaundice monitoring.

A new bereavement suite was close to completion and aimed to provide a calm and private environment for women, birthing people, and their families to use when dealing with the death of their baby.

There were medical gas scavenger systems in place. This ensured safe levels and disposal of medical gases in the maternity unit and reduced staff and patient exposure.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not complete risk assessments for each woman and birthing person including when presenting to triage. Audits were completed but poor compliance was not acted upon. Fetal monitoring in labour was not safe. Women and birthing people experiencing delays in induction of labour were not risk assessed, monitored, and managed safely all of the time. However, staff identified and quickly acted upon women at risk of deterioration and monitored re-admission rates to make improvements.

The service had split triage services into more and less urgent categories. Women and birthing people with issues considered more urgent were seen in delivery suite, and less urgent concerns were dealt with on the day assessment unit. However, the service did not use a standardised risk assessment framework or prioritisation tool to identify women and birthing people in the most clinical need. We saw evidence that the service had considered implementing such a tool in January 2022, but it had not yet done so at the time of our inspection. We found evidence that women and birthing people self-discharged before being reviewed due to long waiting times, and during the inspection we saw women had been awaiting review without privacy or any way to call for assistance: one woman reported a pain score of 8 out of 10 and had not been offered any pain killers. During the factual accuracy process, the service told us they completed a review of the woman's clinical records which stated analgesia had been offered during the day. However, there was no management oversight of this happening, and no management failsafe process to avoid similar situations. This potentially impacted outcomes for women, birthing people, and their babies as there was missed and significantly delayed opportunity for investigation and review. There was no standard operating procedure document (SOP) for triage and the safe care and prioritisation of women and birthing people relied on individual clinical judgement without the support of a framework to aid decision making.

During the inspection it was not clear that the service was able to maintain the safety of care provided within the triage units and we asked the service to take immediate action to assure themselves of this. The service created a SOP which included a risk assessment framework and immediately started a trial of its use. The service guideline for triage processes was last updated in 2018, which may not have been recent enough to reflect current pressures on the service and best evidence-based practice.

The service had implemented a maternity telephone helpline to signpost and triage women, that was staffed by midwives during daytime hours (8am - 8pm). During night-time hours, phone calls were taken by staff on the delivery suite. Delivery suite staff did not have access to the same training, information, risk assessments, and care pathways as the daytime telephone midwives; this created disparity in service provision between daytime and night-time and this was not recognised or addressed by leaders. The service collected data on telephone calls received by the maternity helpline. In February 2023, 325 phone calls were made for general advice, 241 calls related to induction of labour, pain, or bleeding. A further 111 calls were categorised as miscellaneous. The service did not collect data on how many calls were abandoned.

The service conducted an audit and data analysis of women and birthing people attending the unit for triage services to better understand the needs of the local population between June 2021 and August 2021, but it was not clear if the service had completed any recent audits in this area. There was an audit of delivery suite triage waiting times from January 2023 to February 2023, which showed 88% of women and birthing people were seen within 15 minutes of arrival, which is in line with national guidance.

Maternity

Staff did not always complete antenatal risk assessments for women and birthing people. Data supplied by the service showed antenatal risk assessments were completed 72% of the time in February 2023, and 71% of the time in June 2022. No further data was supplied. However, the service conducted a regular audit approximately once per quarter with no signs of improvement in antenatal risk assessment completion. The service did not provide evidence that leaders had acted to improve antenatal risk assessment compliance. Data showed that midwives mostly completed a risk assessment at the point of booking (the first antenatal appointment) however, compliance reduced at subsequent appointments throughout pregnancy.

Staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. Managers audited compliance with women having continuous CTG monitoring during labour once per quarter. Evidence supplied by the service showed that the latest audits on 'fresh eyes' processes were done in September and December 2022, and compliance was 35% and 20% respectively. It was unclear what the service was doing to improve this. The impact of this was women and birthing people having continuous CTG monitoring in labour did not receive adequate or timely reviews of their fetal heartbeat to identify emergent concerns, and therefore care was not safe.

During the inspection, we reviewed labour notes from patient records and saw staff assessed and documented CTGs using various techniques which was not in line with trust guidelines, inconsistent, and potentially caused delays in timely escalation and review. Managers told us that a proforma was being introduced to strengthen safe, holistic reviews of CTGs separate to the 'fresh eyes' reviews. This was following Healthcare Safety Investigation Branch (HSIB) recommendations made in 2022, and managers said improving the quality of interpretation and reviews was challenging, ongoing work. Safety concerns relating to CTG monitoring and interpretation were reported in an incident review in 2018, it was not clear why inconsistent review techniques were still being used by the service in 2023.

There was no formal pathway or guideline for what should happen when an induction of labour needed to be delayed. The induction of labour pathway stated that a senior obstetrician should review each woman or birthing person affected. However, we saw evidence that this guidance was not always followed and there was evidence that delayed induction of labour had led to adverse outcomes for families.

Staff used maternal early obstetric warning score (MEOWS) charts to identify and escalate deteriorating patients. Audit data showed staff did not always correctly or consistently complete MEOWS charts. The MEOWS audits between September 2022 and February 2023 were incomplete for 3 out of 4 clinical areas however, the two audit questions that were answered scored 100%. On the postnatal ward, the audit process had been completed in full. MEOWS completion had improved overall between October 2022 and February 2023, however, was non-compliant in 4 out of 7 questions in the most recent audit.

The service collected data on smoking during pregnancy, including carbon monoxide monitoring which had a compliance rate of 85% tested at 36 weeks gestation, which is below the national recommended guidance of 100%.

The service used locally devised clinical guidance and care pathways that were outside of national recommendation to reduce the likelihood of stillbirth and pre-eclampsia. The service had risk assessed the deviation appropriately through trust divisional care groups and the Patient Safety and Quality Group (PSQG). The service collected data on outcomes and showed that rates of stillbirth had been reduced compared to their own rates using their previous local guidelines. It was not evident that the service had benchmarked local stillbirth rates to national rates or against services that had fully implemented the Saving Babies' Lives care bundle (SBLCBv2).

The service did not use customised growth charts or conduct symphysis fundal height measurements to monitor fetal growth which was not in line with national recommendations. The service used ultrasound scanning as an alternative

method of assessment which had been discussed and approved at board level. Women and birthing people were risk assessed at booking; those in the high-risk category were offered serial scans and those in the low-risk category were offered an ultrasound at 36 weeks gestation. There was no fetal growth assessment for low-risk pregnancies until 36 weeks, which may not be adequate in identifying and monitoring babies with growth restriction.

The service did not have a dedicated, separate transitional care ward for babies requiring additional care. Babies with complex care needs that did not require admission to the neonatal intensive care unit were looked after on the postnatal ward under a 'red hat pathway' which identified babies at higher risk. Managers audited care and records for these babies quarterly. Data supplied by the service showed in December 2022, 39% of babies did not have appropriate documentation of risk factors for sepsis in their records. The service used an online tool to calculate babies' risk of sepsis however, the audit showed 63% of babies had not been screened using the tool. This showed that staff were not working to service policy. There was a risk of avoidable harm occurring to babies at increased risk of sepsis and a lack of appropriate information for clinicians to base their care plans on. The service had further reviewed notes during the audit and found that 58% of babies who had not had the sepsis risk calculation did have care plans present in their records. It was unclear what steps had been taken to improve use of the tool.

Managers monitored the number of babies born before arrival to hospital, or arrival of a midwife (BBA). In the 12 months preceding the inspection the total BBA rate was between 1% and 2% of the total birth rate. This is higher than the national rate of BBA of 0.16% (NHS Maternity Annual Statistics 2021-22), and could indicate issues with staffing, availability of services, or clinical decision making. It is unclear what further processes the service had in place to record, monitor and investigate BBAs, or reduce the number of BBAs taking place.

Managers monitored the number of newborn blood spots that required an avoidable repeat or were done outside of the recommended time frame. The service reported an average rate of 3%, with the highest level reaching 4.1%. This was above the national target of 1% set by Public Health England and there was an improvement plan in place. The service reached target rates for all other perinatal screening tests, except for initial antenatal haemoglobinopathy screening which should be completed before 10 weeks gestation. Haemoglobinopathy is a term used to describe a group of inherited conditions that affect red blood cells. The service reported a 70% compliance rate for timely haemoglobinopathy screening in 2022. The service had a specialist midwife for haemoglobinopathy.

The service looked after a diverse population with many women and birthing people who did not use English as a first language. Some information was available in other languages and the hospital website instructed people to use online translations where information was not available.

Managers monitored postnatal readmissions. Readmission rates were low and there were no outlying trends for why women and birthing people required readmission to hospital.

Managers monitored neonatal readmissions and provided data from the last 6 months. The main cause for neonatal readmission was for jaundice, and between September 2022 and February 2023 the number of readmissions had reduced from 28 to 6 (79% reduction). Community midwifery services could refer babies directly to the paediatric ambulatory service called 'Blue Skies', and this was an area of practice that was working well for staff and service-users.

Trust leaders monitored some key maternity services performance statistics monthly including OASI, massive obstetric haemorrhage, and gestation at booking. At the time of inspection, 3.8% of women and birthing people at the service sustained an OASI which was lower (better) than the threshold of 5%. The service threshold for massive obstetric

haemorrhage was 4% and the actual rate at the time of inspection was 2.9%. During the factual accuracy process, the service submitted evidence to show further maternity metrics had been added to the group integrated performance and quality report, including but not limited to stillbirths, neonatal deaths, newborn brain injury rate, and supernumerary status of the labour ward shift lead.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. A ligature risk assessment had been completed and advised in the absence of being able to remove all ligature risks, individual risk assessments be made for women and birthing people considered at risk.

Staff received training on consent to treatment.

Shift changes and handovers included all necessary key information to keep women and babies safe. Multi-disciplinary handovers took place twice per day, and the team worked well within a wider hospital team for example endocrine doctors, general surgeons, and others. Obstetric patients being cared for on other wards were routinely included in handovers for information sharing, and elective caesareans were discussed. Women and birthing people undergoing complex caesarean sections have gynaecological specialist support in surgery, and the hospital is a specialist centre for placenta accreta (a condition where the placenta adheres into the uterine muscle and beyond).

Theatres were staffed by a dedicated team that did not impact on maternity staffing numbers. Cell salvaging (equipment used to minimise blood loss during surgery) was available 24 hours a day in the operating theatre.

Women and birthing people who chose to birth outside of guidelines had an appointment with a consultant midwife to discuss their care plan.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training, and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. The service did not always make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development. However, managers gave bank and agency staff a full induction.

The number of midwives and healthcare assistants per shift did not match the planned numbers. Data submitted by the service and evidence seen on inspection showed that staffing on the postnatal ward and delivery suite was consistently below the required template of staff. We saw numerous incidents logged by staff detailing the difficulties in maintaining safe care for women without adequate numbers of staff. Staff reported that levels of care frequently felt unsafe, and they were unable to provide the level of care they wished to. Data submitted by the service showed an average of 81% shift fill rate between October 2022 and February 2023.

There was a trust-wide situational meeting held daily to monitor and action any issues faced. Maternity services updates were provided at the meeting by a non-clinical service manager and operational pressures escalation levels (OPEL) framework terminology was not used. The impact of this was although the meeting was told the service had 5 less midwives than it required, an accurate representation of risk within maternity was not presented to trust operational leaders. This meant maternity services limited and lost opportunity for a trust-wide approach to mitigate the risks of low midwifery staffing in order to maintain safety.

The ward manager could adjust staffing levels daily according to the needs of women using a local staffing escalation book. However, during inspection we saw evidence that the book was not always used effectively or revisited throughout the day to respond to changing circumstances within the unit. Staff told us wards were regularly understaffed, lack of meal breaks was commonplace, and there was not adequate provision of supernumerary unit co-ordinators with a 'helicopter view' to monitor acuity and maintain the safest levels and distribution of staff. This was not in line with national recommendations. Skill mix was a recognised issue within the service, data collected on inspection showed some shifts filled with mostly junior staff, without adequate experienced staff members to support or take on more complex patients. There was no clear, effective escalation pathway to follow in times of short staffing and no way for managers to monitor and mitigate the risk posed to staff working on-call shift patterns.

The service sometimes monitored 'red flag' events, which are indicators that something may be wrong with staffing levels, and these are input into monthly incident forms and quarterly maternity dashboard figures. During the inspection it was not evident there was a clear pathway for recording 'red flag' events, and quarterly input to the dashboard may mean that staffing acuity was not accurately represented and responded to by service and trust leaders in a timely way.

The service commenced use of an online staffing acuity tool for intrapartum areas in November 2022. This aimed to assist staff and managers to demonstrate and maintain safe staffing and redeploy staff to the areas where they were most needed. Compliance in completing the acuity tool was 55% on delivery suite and 10% on the birth centre, which was below the target rate of 85%. The impact of this was an accurate representation of staffing pressures was not able to be made. However, data entered into the tool in February 2023 showed staffing was safe 60% of the time, which was lower than the target rate of 85%, and the service was 2 or more midwives short 16% of the time. However, the service redeployed staff to the delivery suite from other areas of the service when required. Data supplied by the service showed that these figures were an improvement compared to previous months.

During February 2023, 160 shifts on the postnatal ward, 121 shifts on the antenatal ward, and 272 shifts on delivery suite and triage were filled using bank and agency staff including midwives, administrative support, maternity support workers, and nursery nurses. This indicated a heavy reliance on bank and agency staff to maintain safe staffing levels. There was an induction pack for bank and agency staff unfamiliar with the service.

In the 12 months before the inspection, the unit had closed 4 times due to short staffing. All 4 of these closures occurred in September and October 2022. In times of high acuity and low staffing, the service paused home births and closed the birth centre in order to maintain safety and utilise staff more effectively. The birth centre was closed regularly between November 2022 and February 2023. However, this impacted on women's and birthing people's birthplace choice. Staff said that women and birthing people were offered low risk care on the delivery suite when the birth centre was closed.

In 2021, an external staffing template review was carried out and recommended the service required an additional 25.24 whole-time equivalent (WTE) clinical staff at bands 3-7, of which 11.2 WTE were midwives. It is unclear how staffing levels at the time of inspection compared to the template, or if the template produced in 2021 remained fit for purpose.

It was unclear if the service had reducing vacancy rates. According to service reports, the vacancy rate had dropped to 4.9% in January 2023 which was lower (better than) the trust target of 11%. However, data submitted by the service showed in February 2023 the vacancy rate was 8.2% for midwives at band 5 and 6 level which was the highest (worst) vacancy rate since October 2022.

The service had high turnover rates. The turnover rate for December 2022 to January 2023 was 21.5% which was higher (worse than) the trust target of 13%. We did not see evidence of exit interviews taking place to identify trends or themes that could be addressed to aid retention.

The service had high short-term sickness rates and the sickness rate for December 2022 to January 2023 was 5.8%, which was above (worse than) the trust target of 3.5%.

Managers monitored rates of annual appraisals for staff. Data submitted by the service showed an average of 45% of midwives had received an annual appraisal.

To supplement midwifery staff numbers, the service employed nurses, including high-dependency unit nurses to provide some aspects of maternity care. The service carried out competency tests to ensure these staff had the knowledge and skills to keep women and birthing people safe.

The service employed specialist midwives in a variety of roles including, but not limited to practice development, safeguarding, perinatal mental health, fetal monitoring, and a digital midwife. Managers made sure staff received any specialist training for their role.

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. The service prioritised medical staffing on the delivery suite. The delivery suite had 110-hour consultant obstetrician cover on site. This was more than Royal College of Obstetricians and Gynaecologists Safer Childbirth guidance on minimum standards for labour care in maternity units with 4000 to 5000 births a year. Consultants and doctors mostly did two labour ward rounds per day which was in line with national recommendations however, these were not always formalised practice and were dependant on individual practitioner choice and availability. There was onsite consultant cover daily from 8.00am to 8.30pm, and a consultant was resident overnight.

The service employed 25 consultants and 23 junior doctors. The service had variable rates of reliance on locum staff for junior doctor positions within maternity services.

Managers told us that medical staffing was challenging and that doctors working less than full time impacted the junior doctors' rota. The service did not use external locums and relied on the in-house team to provide emergency cover where necessary. It was unclear what measures were in place to protect doctors from working excessive hours, or how extra shifts were monitored for safety and staff wellbeing.

Results from the General Medical Council trainee survey 2022 showed the trust was in the bottom 25%, but was not an outlier, for regional teaching. There was a considerable deterioration for this metric over the two latest survey years. The trust saw a very considerable improvement for handover in 2022. It was previously a negative outlier for this metric in both 2019 and 2021. There were also substantial improvements for teamwork, supportive environment, and facilities. For all three metrics, the trust went from being in the bottom 25% (but not an outlier), to being in the middle 50% of trusts.

Maternity

Records

Documentation was not always completed in full and multiple records systems were in use. However, staff mostly kept accurate records of women's care and treatment. Records were clear, up to date, stored securely, and available to all staff providing care.

In the bereavement suite we found adequate documentation had not taken place. We escalated this to staff on the day and they carried out checks to ensure that families and their babies had received proper care and treatment where there were omissions in the documentation. Staff told us that there would be a new process for signing documentation in the bereavement suite with immediate effect.

The service did not use personalised growth charts for babies, which may impact early recognition of small babies. When women and birthing people attended triage, arrival and triage times were not clearly documented and therefore it was not possible to ascertain accurate waiting times. This impacted on audit results and oversight of risk.

There were several electronic records systems in use as well as paper notes. This was a risk to accurate and contemporaneous record keeping; this had been recognised and was on the service risk register, with a digital transformation project planned for 2024.

Managers audited records in a number of ways. Data supplied by the service showed that 49% of perineal repair documentation in January 2022 was incomplete and there were no action plans detailed to improve compliance. The impact of this was incomplete information for women, birthing people, and healthcare professionals, and the potential for inappropriate care taking place.

Staff used a standardised tool to ensure relevant information was shared during handovers (SBAR, or Situation, Background, Assessment, Recommendation). Managers audited use of the tool on each area of the maternity unit. Audit data for January 2023 to March 2023 inclusive showed compliance rates of between 70% and 100%. Women's notes were comprehensive, and all staff could access them easily. During the inspection we looked at 11 sets of records. Swab counts after delivery were recorded in 10 out of 11 notes and staff completed these notes appropriately overall.

When women transferred to a new team, there were no delays in staff accessing their records. Women sometimes attended the service from out of area and had bookings completed locally.

Records were stored securely.

Medicines

The service did not always use effective systems and processes to safely prescribe and record medicines, and they were not always stored safely. However, staff administered them safely.

Controlled medicines did not always have safe methods of recording accurate amounts measured. We found some out-of-date medicine on emergency trolleys. Medicines freezers were consistently recording lower temperatures than recommended for storing medicines. Temperatures outside of range had not been appropriately acted on, which could impact the effectiveness and safety of medicines inside. We escalated all of this to staff on the day. Staff disposed of out-of-date medicine and replaced it immediately, and pharmacy were contacted to assist and resolve the other issues.

Refrigerators for medicines did not have checks completed every day, and some out-of-range temperatures were recorded and not acted on. We escalated this on the day of inspection and staff contacted the hospital pharmacy to investigate and resolve the problem. Evidence submitted by the service showed there were issues with clinical refrigerators being used inappropriately, for example for storing food, and managers were monitoring this.

Managers monitored safe management of medicine via monthly audits. In February 2023 the unit scored 82.3% compliance which was below the trust target of 90%. The delivery suite was 100% compliant and the postnatal and antenatal wards scored 72%-73%. It was not clear where the shortfalls of compliance were or what action the service was taking to improve these figures.

Emergency medicines were stored in unlocked fridges inside locked treatment rooms for ease of access to staff in an emergency. In theatres, controlled drugs were stored in a locked box in an otherwise potentially insecure location. There were risk assessments in place for this however, these had not been reviewed since 2019.

Staff mostly completed medicines records accurately and kept them up-to-date. During the inspection we reviewed 10 medicines charts and found 2 had incomplete information and 1 contained an antibiotic prescription that had never been administered.

The service provided competency training and testing for staff for medicines management to ensure the safe administration of medicines.

Patient group directive medicines (can be given by midwives without a prescription) were clearly listed for reference inside medicine cabinets.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff stored and managed prescribing documents safely.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services.

Incidents

The service did not manage safety incidents well as learning from incidents was slow, and not shared effectively with the whole team and the wider service. However, staff recognised and reported incidents and near misses and managers investigated incidents. 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.

Staff reported serious incidents clearly and in line with trust policy. The service shared data about recent serious incidents. Incidents were discussed at trust-wide Serious Incident Declaration Meetings (SIDM) and panel members decided whether incidents met the threshold of a 'serious incident' which should be reported nationally. Evidence submitted by the service showed that the SIDM regularly graded incidents inappropriately for review as 'adverse incidents', instead of 'serious incidents', including stillbirths, massive obstetric haemorrhage and uterine rupture. These incidents were then investigated internally under the trust's 'adverse incident' policy. The impact of this was missed opportunity for learning and development to provide the safest care possible, and a lack of transparency at an executive level in sharing serious incidents. Some incidents shared by the service and categorised as internal were appropriate for

an external review to drive improvement and learning. During the factual accuracy process, the service told us all these incidents were subject to a full clinical review, and a rapid response report was presented to the SIDM for decision about the level of investigation required. The trust told us SIDM panel membership included representation from the Integrated Care Board and immediate safety actions were undertaken.

When reviewing incidents reported by staff, we found incidents were harm-rated inappropriately according to national guidelines (NHS England National Reporting and Learning System, 2019), with incidents often harm-rated at a lower grade than appropriate. An emergency hysterectomy was rated as low harm. This did not meet the definition of low harm. Obstetric anal sphincter injuries (OASI), also known as 3rd and 4th degree perineal tears, were routinely downgraded from moderate harm rating, which is appropriate, to no or low harm. A similar pattern was seen with cases of obstetric haemorrhage. The service reported other incidents incorrectly as low or no harm, such as antibiotic overdose, birth injury to a neonate causing impairment of the suction reflex (which affects feeding), and mismanaged postnatal discharge process resulting in no postnatal care in the community. This caused missed opportunity for learning and improvement, which potentially impacted on provision of safe care. However, the service told us the severity of incidents was altered for incidents where it was assessed that there were no care or treatment concerns.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. There was a never event in February 2023 of a retained swab. The service provided evidence to show management of the incident. However, during inspection most staff we spoke with did not have any knowledge of the never event occurring. This was indicative of poor information dissemination and showed shared learning from events was not effective. We saw evidence that details of the never event had been discussed at the senior midwives' meeting, and that some incidents were added to training days for discussion.

Staff knew what incidents to report and how to report them. However, staff we spoke to said they did not always report minor incidents due to staffing and time pressures.

There were 280 incidents reported in maternity between January 2023 and March 2023, and there were no incidents that were over 60 days old. At the time of the inspection, there were 101 open incidents. There were no overall themes within the incidents however, categories with the largest amounts of open incidents were cancelled or rescheduled appointments, postpartum haemorrhage, and appointment waiting times. The total number of incidents reported in the 60 days preceding the inspection was 356. Of these incidents, the most prevalent themes were postpartum haemorrhage, shoulder dystocia (the baby's shoulders becoming stuck in the birth canal during birth), 3rd and 4th degree (most severe) perineal tearing, and poor staffing.

Managers investigated incidents. Women and their families were involved in these investigations. Documentation provided by the service did not show the service monitored ethnicity when analysing and learning from incidents. The impact of this was limited or missed opportunity to understand health inequalities faced by service users and make improvements.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. There was a pathway for action after incidents including a hot debrief with staff involved which is considered good practice, and a multi-disciplinary meeting within 14 days. Staff were trained in how to carry out effective after-action reviews however, it was not clear that this had been fully embedded into practice.

Maternity

Is the service well-led?

Inadequate

This was our first rating of maternity services without gynaecology services at St George's University Hospital. We rated well-led as inadequate.

Leadership

Service leaders had the skills and abilities to run the service but lacked support from the executive team. They understood the issues the service faced. Service leaders were sometimes visible and approachable in the service for women and staff. Executive leaders were not visible.

During the inspection we found delivery suite to be a chaotic environment without clear organisation or leadership to carry out work with a calm and systematic approach. Service-level staff said service leaders were not visible on wards or responsive to concerns, which was indicative of poor communication throughout staff groups.

Safety champions conducted ward visits on average every 2 months to assess the maternity unit environment, observe care, and engage with staff. They had identified and acknowledged staffing shortages and problems with the buildings' state of repair, as well as staff concerns that issues were not being addressed fast enough. The service had 2 maternity safety champions, an executive and a non-executive. The non-executive safety champion was newly appointed and was not yet embedded into the role.

Maternity services at St George's University Hospital were part of the Women and Children and Diagnostic Therapies Division. Maternity and gynaecology were managed by the Director of Midwifery & Gynaecology, a Clinical Lead, and a General Manager. They were supported by a Deputy Director of Midwifery, a team of matrons and consultant midwives, and obstetric doctors. There was a manager on-call system to support escalation of service-specific issues, and managers were called often to resolve issues with short staffing. The on-call system was being reviewed for sustainability and effectiveness.

There was a comprehensive training needs analysis and matrix, but it was not clear how the service was supporting staff to attend mandatory training.

Vision and Strategy

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

The service had a clear vision and strategy focussed on 3 main areas of care: woman-centred, evidence-based, and staff support. The vision clearly reflected on challenges and strengths of the service, including maternal and fetal medicine provision, and aimed to build on areas of good practice. The strategy had a large number of workstreams and the impact of this was potential slow implementation of change and improvement measures.

Maternity

Service leaders told us a main aim was working to reduce health inequalities in maternity, and they were working with the LMNS lead to achieve this.

Culture

Staff did not feel supported and valued. The service tried to promote equality and diversity in daily work. The service had an improving culture where women, birthing people, their families, and staff could raise concerns. Staff were focused on the needs of women and birthing people receiving care.

Staff described siloed working within teams, and a lack of two-way communication between maternity staff, maternity leaders, and trust leaders. Staff said service leaders listened to their concerns, but they were not taken seriously, acted upon, or responded to. Staff told us problems were attributed to staffing by managers, and managers had told them nothing could be done about it. Mitigating actions were not shared openly with staff which contributed to low morale. Most staff said they had good relationships with their line managers however, service senior leaders were not always visible to service-level staff. Line managers said that service senior leaders were approachable, visible and supportive to them. This indicated a disparity in experience between various tiers of staff.

The service was reliant on bank staff to bolster staffing numbers. However, staff told us that reductions to the agreed rate of bank pay were implemented without adequate communication from managers. The impact of this was staff had an unexpected reduction in their income, and lack of communication and transparency affected morale and trust in maternity leadership. During the factual accuracy process, the service told us they acknowledged that communication could have been better and apologised to staff.

Staff described waning enthusiasm, burn out, low morale and a negative impact on culture within the unit. Staff said there was misalignment on the culture of the unit between service-level staff and the managers. Culture between various levels of management and between wards could be problematic. In particular: communication, equal opportunities, and when staff required redeployment due to low staffing, because there was no formal process in place.

Out of 97 indicators in the 2022 staff survey, 11 questions scored better than the trust score, and 35 scored better than the previous year. Some staff told us they did not feel able to raise concerns safely, and that management style carried blame and made staff feel undervalued.

The service held a listening event in December 2022 and gained responses from 123 staff members. Results were a mix of positive and negative comments. Themes in the responses were low staffing, workload, and lack of resources, as well as poor or no facilities for staff breaks. Staff spoke about good team and peer support however, voiced concerns about management and leadership styles and confidence in their seniors. These themes remained evident in staff interviews that we carried out during the inspection. Results of the listening event showed that staff were concerned about maintaining safe care. There was a disparity in responses that depended on the support and leadership style of staff's individual managers. Staff told us that these concerns had been evident for a long time and that there had not been any significant changes from leaders and managers to alleviate the issues. It was not clear that there was enough awareness and input from trust leaders of the issues faced within maternity.

Staff told us poor culture was an ongoing concern, but there had been improvements in culture within the unit since the appointment of the current Director of Midwifery. Staff described happy working relationships on the wards and were proud of the service's kindness to women and birthing people. Staff told us there were positive relationships between midwives and doctors.

Maternity

Staff told us they felt leadership positions and job opportunities were not made transparent or equally accessible to all staff. This was reflected in the trust level Workforce Race Equality Standard (WRES) data. The data reviewed related to the overall hospital and was not specific to maternity services however, it was illustrative of our findings of staff experiences within maternity services, and how the trust managed equality issues for staff groups. Data submitted to WRES demonstrated that whilst there had been significant improvements in the last 2 years, there were still statistically significant differences between White staff, and staff from ethnic minority groups for 5 out of 9 indicators. These showed that staff from ethnic minority groups (compared to White staff in the organisation) were more likely to experience harassment, bullying, discrimination or abuse from patients, colleagues, and managers, felt they had less access to equal opportunities, and significantly less access to senior roles and board level roles, with the trust performing in the bottom 6% of all trusts nationally in the last metric. However, the WRES report also demonstrated that compared to White staff, staff from ethic minority groups reported greater access to mandatory training and continuing professional development. The percentage of staff from ethnic minority groups experiencing harassment, bullying or abuse from staff, colleagues, and patients, in the last 12 months was lower than the benchmark group nationally.

The trust published NHS WRES data and an accompanying action plan which was rated 'outstanding' by the National WRES Team. Service leaders said they were making equality issues 'business as usual' and saw the benefit of supporting diversity in staff. For example, staff mentorship programmes were in place. Staff told us that this was not visible to them, and there was more the service could do to improve equal opportunities in the workplace and cultivate a more diverse staff group representative of the local population. Staff said more work was needed to understand outcomes and experiences for ethnic minority women in the local area.

The Workforce Disability Equality Standard (WDES) is a set of measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. There were 3 out of 10 WDES metrics where the trust performed worse than the national average. The trust reported improvements compared to the previous year in 5 out of 10 WDES metrics and has taken steps to raise awareness of disability in the workplace.

The Local Maternity and Neonatal System (LMNS, a group of organisations working together to improve services within their local area) was in the process of creating an equity and equality action plan to tackle both health inequalities for women, and race inequality for staff members. It planned to do this using training days, data collection, improving community engagement, better listening to women using services, and acting on the information collected.

There were networks to represent staff from ethnic minority groups, disabled staff, women, and LGBTQ+ staff. The maternity service also had a local midwifery-led ethnic minority staff network.

Following complaints, the service carried out junior doctor surveys every 6 months to foster and maintain positive culture. There was a programme of pastoral support and individual HR management where required. The service had documented issues with negative culture within maternity and this was acknowledged by trust leaders who told us it was considered historical, and that ongoing work to maintain culture was continuing. Recent junior doctors' surveys were positive and indicated change for the better.

Feedback from medical staff was positive about the quality of training and support for junior doctors. Staff told us that consultant obstetricians were approachable and always attend when asked. All members of the multi-disciplinary group reported positive team working and flattened hierarchy within the clinical areas.

The service had 5 professional midwifery advocates (PMAs) to support women, birthing people, and staff with any concerns. Staff said PMAs were approachable and helpful however, involvement was ad-hoc and there could be a better

process for accessing support. Service leaders were committed to improving culture within the service. They had enrolled on NHSE culture and leadership programmes, held regular one-to-one meetings with staff to gain feedback and listen to concerns, and were working towards more cohesive wellbeing measures being put in place for staff. The service was awarded a 'quality mark' for its preceptorship programme for newly qualified midwives.

There was a 'gratitude box' in use on the postnatal ward for staff to compliment and commend colleagues for their work.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Governance

There were ineffective governance processes throughout the service and with partner organisations. However, 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.

We found baby deaths had occurred in October of 2022 and were not discussed at the SIDM until 30 January 2023. This was a slow response to serious incidents to examine if and where things had gone wrong, and implement improvements to care.

Improvements required in practice were identified following the serious incident of a baby death in 2018: CTG interpretation, handover of care, learning lessons from poor outcomes, and investigating incidents in a timely way. During the inspection we found these recurring themes were ongoing within the service nearly 5 years later, this was indicative of ineffective governance and risk management systems, and ineffective learning from incidents taking place. During the factual accuracy process, the service told us that a number of improvements had been developed and implemented to try and address these ongoing issues, including the upgrade of CTG monitors, installation of a CTG central monitoring system in the induction of labour area, annual review of training to reflect learning from case studies, and acting as the host of a national maternity multi-disciplinary training programme. During the factual accuracy process, the service told us they worked to reduce staffing pressures by pausing the birth centre and home birth service, asked non-clinical staff to undertake clinical duties, and rescheduled training days to be able to meet the demands of the delivery suite.

During the inspection we found an incident where a baby had died whilst the mother was awaiting a delayed induction of labour. There was no policy or pathway in place for staff to follow if an induction of labour was delayed, and the result of this was that opportunities to intervene and potentially change the outcome were missed. During the inspection we found there was no policy for delayed induction of labour despite the incident occurring 5 months prior. The service had not completed investigation into this incident more than 3 months afterwards, and the incident was not investigated as a 'serious incident' but an 'adverse incident'. This was decided by the trust's serious incident declaration meeting panel.

We saw evidence that serious incidents were discussed at the trust board and adverse incidents were not. However, the Board received a monthly maternity services report which included the details of all baby deaths reported via PMRT. The Board also received a quarterly PMRT report which included the lessons learnt for the service and the actions to be taken in response.

There were quarterly meetings with the Local Maternity and Neonatal System (LMNS) to discuss serious incidents. We saw evidence in meeting minutes from September 2022 that St George's University Hospital had presented findings from

a 'deep dive' into stillbirth and neonatal deaths that had occurred in November 2021. This was a long time between the incidents and shared learning taking place, the impact of which was potential delays in improving care. From the 3 recent incidents shared at the meeting, the service had identified cardiotocography (CTG) monitoring as a common theme in incidents, alongside staffing pressures, and workload. During the factual accuracy process, the service told us rapid response reviews were completed and actions were taken. All these themes remained ongoing problems at the time of inspection, which was indicative of ineffective action by leaders to resolve and mitigate them. During the factual accuracy process, the service told us meetings discussed Healthcare Safety Investigation Branch (HSIB) cases, and the breakdown of those cases was comparable with national data.

Staff followed policies to plan and deliver care. There was a guidelines review and ratification meeting for updated clinical pathways. However, guidelines were not always kept up-to-date, and this has been commented on elsewhere in the report. In particular, the service's policies on governance and risk management, obstetric emergencies, post operative and high-dependency unit care were all out of date.

Safety champions did not have a comprehensive overview of population demographics and the work that the maternity service was doing to address health inequalities. Some listening events and staff surveys had been carried out in 2022 however, safety champions were not aware of the outcomes nor had seen reports relating to these. They understood some of the issues faced by the service but lacked detailed knowledge and understanding of underpinning issues required to improve.

The board and non-executive maternity safety champions visited maternity wards at least quarterly and submitted notes from the last 3 visits in November 2022, January 2023, and February 2023. Safety champions spoke with staff about their working experience and assessed the unit environment. In November 2022 it was noted estates were in poor state of repair, final work on the new bereavement suite was delaying its use, and the reconfiguration of the delivery suite triage area was also delayed. Staffing levels were continuously escalated by members of the maternity team, and security breaches were noted. Breaches and security concerns were logged in senior leadership meetings regularly however, action to mitigate and eradicate these was slow. There was little improvement noted between the visits in November 2022 and February 2023, which indicated safety champion visits had not resulted in tangible changes and may be ineffective to resolve issues faced by the service. This meant that the trust could not be assured that systems and processes in place worked as intended. Board meeting minutes we saw showed that maternity services issues such as IT systems, EMBRRACE-UK report findings, and CNST were discussed.

The service had meetings to discuss the Perinatal Mortality Review Tool (PMRT) and baby deaths that occurred after 22 weeks gestation until the neonatal period. Managers monitored baby deaths and investigated when things went wrong. A quarterly report was put before the trust board however, information and action plans within the report submitted by the service did not always identify issues to learn from and minimise or prevent reoccurrence. We saw evidence of collaborative PMRT panel reviews that had taken place. There were mortality and morbidity case reviews twice per month which discussed good practice and areas for improvement with the clinical teams.

The service had monthly maternity governance meetings to discuss incidents and other issues. Monthly service reports on Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme were made to the trust quality committee. As of February 2023, the service had not achieved compliance in 4 out of 10 areas of the maternity incentive scheme: transitional care, midwifery workforce planning, Saving Babies' Lives Care Bundle v2 (SBLCBv2), and in-house training. There were action plans for achieving some of these in the future however, it was not clear whether they were effective or achievable. The service did not plan to implement SBLCBv2 as it used its' own policy which is commented on elsewhere in this report. The service monitored compliance against PMRT requirements as part of the maternity incentive scheme and the service had achieved compliance with this.

Service leaders had conducted an options appraisal in March 2023 to identify the best way to mitigate senior midwifery staffing and the manager on-call system. It was not yet clear what actions were taken following this however, it demonstrated service leaders maintained oversight of, and were attempting to tackle issues faced.

The obstetric team had a monthly meeting to discuss any issues including covering clinics, areas of special interest and any emergent or ongoing concerns. However, actions from the meeting were sometimes slow paced.

Senior midwifery shift leaders had monthly meetings to share information for example high risk or safeguarding patients, estates issues and updates, and general unit updates.

Management of risk, issues and performance

Leaders and teams did not manage performance effectively. They identified and escalated relevant risks and issues and sometimes identified actions to reduce their impact. Leaders had plans to cope with unexpected events.

Action to mitigate and reduce risks was slow or ineffective. Risks were discussed repeatedly at monthly and quarterly meetings with little or no progress noted, such as maternity governance, women's directorate, trust quality committee, maternity and gynaecology unit, and divisional triumvirate meetings. Leaders attended meetings to discuss ongoing and emergent risks, and were aware of issues within the service. However, in the meeting minutes provided by the service there was no evidence of mitigating actions, improvement measures, or timely set-out action planning to reduce the impact and incidence of the risks identified.

The service monitored emerging and ongoing risks via a risk register. At the time of inspection, there were 11 items on the risk register and managers told us the most serious risks were staffing, IT systems, and the infrastructure of the aging hospital buildings. Managers told us that any risks rated as extreme were added on to the corporate risk register to ensure trust-wide oversight. However, it was rare that risks were rated as extreme and therefore automatically omitting risks rated as serious from the corporate risk register may lead to lack of oversight and slow or poor risk management. The risk register and associated meetings did not show executive leaders had sufficient oversight and understanding of risks within maternity services. The risk register contained long-standing risks that appeared to be normalised and tolerated by the service, especially maternity staffing levels. This did not provide assurance the maternity risk register functioned effectively, or the service responded to risks in a timely way.

Service directorate meetings documented discussion of risks however, some risks were accepted by directorate leaders. For example, staffing was documented as there being no change for the foreseeable future, with minimal discussion about mitigations that had been put in place or new ideas to alleviate pressures sooner. Meeting minutes showed the directorate discussed complaints and compliments but had not reported any themes to identify areas for improvement.

In the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) perinatal mortality surveillance report published in October 2022 (based on births in 2020), the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher (worse) than the comparator group average for all births, and for births excluding congenital anomalies. We saw evidence that this was discussed at the trust board. In January 2023 the trust commissioned an external review of stillbirths and neonatal deaths that occurred during 2020 and the report was due in October 2023. The service continues to report all stillbirths and neonatal deaths via PMRT.

Maternity

The trust was in the upper 25% of all trusts reporting for major (more than 1500mls) postpartum haemorrhage (PPH). In November 2022, the rate of major PPH was 49 per 1000 births, compared with the national average of 30 per 1000 births. This may indicate a need for clinical quality improvement, but the service did not acknowledge or submit any data to support improvement measures in this. However, the hospital is a regional centre for complex women, birthing people, and babies from the wider geographical area and this may skew the data.

The trust's annual staffing review dated 2022-23, did not make any reference to maternity staffing pressures, therefore there was not adequate oversight of service level issues at board level. Incidents relating to low staffing were frequently reported by staff and the management response was 'ongoing recruitment in progress' which did not address safety concerns in an appropriate, detailed, or timely manner. At the time of the inspection there was no listed advertisement for midwifery staff at St George's University Hospital. During the factual accuracy process, the service told us that there was an embedded rolling recruitment programme, and an advert was listed every 6 weeks, however no evidence of this was seen and there was no advert listed at the time of report publication. Staff rate of pay for bank shifts had been reduced with insufficient warning, and this has been commented on elsewhere in the report. The service acknowledged communication with staff could have been improved and apologised to staff. During the factual accuracy process, the service told us the rate of pay was historically increased to reduce the over-reliance of the service on agency midwives, and was subsequently reduced in line with bank rates paid in other areas of the hospital.

Service leaders told us there was a bi-annual workforce report submitted to the board and that they were awaiting a response from the trust executive team for 2023. Service leaders told us that it was a challenge to maintain supernumerary status of the shift leader on delivery suite, and that concerns made to the trust board were met with competing demands from the rest of hospital services. There was a dedicated finance team that leaders met with monthly to discuss staffing issues.

The service was planning to pilot a bank scheme for staff to work any hours they could, instead of committing to a whole shift. In the pilot scheme, staff could opt to work any period of time upwards of 2 hours, to encourage staff to work flexibly to support the service. The service had recently implemented a recruitment and retention post to improve attrition rates.

The service continued to provide midwifery continuity of carer at an average rate of 26% despite poor staffing levels and high levels of complexity on the unit. National recommendations made in September 2022 instructed trusts to pause or cease continuity of carer until staffing was adequately safe. It was unclear why leaders had not followed national recommendations despite staffing rated as extreme and the most serious risk on the service risk register. Continuity of care teams were not working in deprived areas to target the most vulnerable, women and birthing people from minority ethnic groups, and those most in need of those services, therefore did not adequately address health inequalities. However, the service told us that midwives working in the continuity model worked shifts in the maternity unit to assist with low levels of staffing.

The estate department's response to incidents in the maternity unit was slow and staff raised incidents on a regular basis to deal with wide-ranging issues affecting care. Between November 2022 and March 2023, there were 400 incident reports about the estate, 69 of which remained open. There were 15 out of 69 (21%) open incidents considered high priority and had not yet been resolved. Approximately 20% of incidents were not resolved in 10 days however, this could be because the work was considered non-urgent. Reports of issues included: unsafe temperature maintenance in clinical rooms, broken showers, damaged panic alarms, poor integrity of walls, leaking birth pools, mould in bathrooms, blocked toilets, broken medical gas panels (reported 4 weeks before and not resolved at time of inspection), incomplete PAT testing of electrical equipment, no hot water supply, blocked sink, and no light source. Prior to the inspection, the unit had experienced leakage of sewerage into the delivery suite from above, which posed a significant health hazard

and risk of infection to staff and patients. The source of the sewerage problem was identified, and repairs had been made. There was evidence of actions to mitigate estates issues on the risk register although actions took several months, and in one case, more than a year to complete. There was no evidence of ongoing actions to improve the estate department's response; although weekly meetings had been set up between service leaders and leaders of the estates department, it was not clear how these worked to minimise risk and expedite completion of work.

Managers and staff carried out repeated audits to check improvement over time. The service shared audits with us including, but not limited to record keeping, fetal monitoring in labour, induction of labour, epidural effectiveness, and venous thromboembolism (VTE) prophylaxis. Some audit results did not appear to have been acted upon, for example record keeping and CTG reviews during labour, and these have been commented on elsewhere in the report. We did not see evidence of action plans to improve outcomes of poorly compliant audits. However, there was evidence that some audit results had been used to drive improvement, for example ensuring more women and birthing people have access to information regarding induction of labour, and use of epidurals. There was a comprehensive programme of audits taking place, but the service did not always keep records of whether audit results were compliant with national standards or if action plans were required and carried out. Maternity governance meeting minutes did not evidence that audit results were scrutinised and discussed to implement improvement planning. The impact is that there was not always evidence to show learning and improvement was identified and carried out as a result of audits.

The service provided evidence showing that 9 out of 46 (19.5%) clinical guidelines and 7 out of 25 (28%) standard operating procedures (SOPs) were out of date. A further 4 SOPs were not yet ratified for use. This meant that potentially 28% of these documents were not fit for purpose, including the guidelines for obstetric emergencies, post operative and high-dependency unit care, management of babies born to women and birthing people taking psychotropic medicine, and the governance and risk management strategy.

Some guidelines had been updated since 2021 but did not mention changes to care implemented due to the COVID pandemic, for example the antenatal care guideline did not reference promotion or administration processes for COVID vaccination. Assessment of fetal growth was referenced in the fetal medicine unit guidelines under a paragraph labelled pre-eclampsia, and not within the antenatal care guideline. We did not see any references to management of babies under the 10th centile or over the 90th centile of growth. Lead clinicians were asked to explain the care pathways in relation to fetal growth and agreed that it was not clear to staff what to do. The impact of this was guidelines were not set out clearly and in an intuitive way, and staff were unable to find adequate guidance to support them in giving safe care. Governance meeting minutes that we saw did not show that leaders were aware of or discussed guidelines approaching renewal dates in order to drive and manage guideline updates in a timely way.

The service had long guidelines that combined several areas of care, for example safeguarding in maternity did not have a separate guideline and was found as part of the perinatal mental health guideline, which may not be relevant. The impact of this was information was not easy to find in a timely way. During the inspection we asked staff to show us guidelines and some staff did not know how to access them. We spoke to managers about this after the inspection and they told us this would be addressed and sent us evidence of an infographic to help staff to access guidelines.

The service submitted data to the clinical negligence scheme for trusts maternity incentive scheme. It was unable to report compliance to the scheme in 4 areas which are listed elsewhere in this report. Leaders reported building an action plan to achieve compliance in the maternity incentive scheme.

The service reported data to the Neonatal Network Quality Dashboard for benchmarking against the wider local network. Data from St George's University Hospital was comparable or better than neighbouring trusts however, scored below the national standard rate in several categories.

Maternity

The service was compliant in all areas of initial recommendation from Ockenden Report 1 (2020) and was working towards full compliance on Ockenden 2 (2022). The service had an Ockenden assurance visit in May 2022, which noted positive themes such as good working relationships, proactively tackling incivility and racial unconscious bias, and various quality improvement projects such as elective caesarean section pathways. The Ockenden assurance visit also provided recommendations for further improvement. These included senior maternity leaders attending trust board to ensure there is adequate and current oversight and understanding of maternity services, further communication between the Maternity Voices Partnership (MVP) and the non-executive maternity safety champion, and further work on broadening the reach of the MVP in groups of the local population who may be harder to engage with. Documents provided did not show that any of these recommendations had taken place. Board assurance meeting papers did not record attendance by any senior leaders from maternity services although there was an agenda item dedicated to maternity in the quality assurance meeting. During the factual accuracy process, the service told us that the recommendations were considered by the board and a decision was made that maternity services would be represented by the group Chief Nursing Officer, who is the executive board member with statutory responsibility for maternity services. During the factual accuracy process, the service also told us that further communication between the non-executive maternity safety champion and the MVP was in place since August 2022.

The service had conducted a gap analysis with reference to the findings of the Kirkup Report (2022). The Kirkup Report investigated failings in maternity and neonatal care that led to baby deaths. The broad areas for action, associated recommendations, and an improvement plan was discussed at trust board. As a direct result of this discussion the trust board agreed to commission a review of the culture in maternity services. Results of the review were expected in October 2023.

Detailed business continuity plans were in place to deal with any unexpected disruptions to care.

Information Management

Old information systems created difficulty for the service to collect and analyse data. Data or notifications were mostly submitted to external organisations as required. Most staff could find the data they needed, in accessible formats, to understand performance, make decisions and improvements. The information systems were secure.

The service was unable to submit all relevant data to the maternity services data set because their systems did not support adequate data capture and analysis.

The service used a maternity dashboard however, did not share all of the dashboard information with CQC during the inspection. Managers told us the dashboard was updated quarterly, which may not be frequent enough to monitor performance and issues adequately or safely. However, there was evidence to show that maternity services performance was monitored monthly at a sub-committee of the trust board.

The service used several information systems and relied on an older maternity information system which did not allow the service to input and record data required as part of the maternity incentive scheme. The service had recently procured a new maternity information system which was planned for implementation in late 2024. The impact of this was the difficulty for the service to find all the data they needed. There was a digital midwife leading on this work.

Engagement

Leaders and staff engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Maternity

Results from the CQC maternity survey (2022) showed St George's University Hospital performed as expected in 43 out of 51 questions, worse than expected for 1 question, and somewhat better, better, or much better than expected in 7 questions. This was a statistically significant improvement of 5 points compared with 2021 results. There were 148 women and birthing people who took part in the survey, they reported high levels of satisfaction with the information they received throughout pregnancy and birth. However, the trust's lowest scoring questions all related to provision of postnatal care. The trust was in the top 3 performing hospitals in London in the antenatal and labour sections of the survey, and around average in the postnatal section. Women and birthing people said that staff were caring, friendly, and took time to explain information.

During the inspection we invited women and birthing people who had used the service recently to give feedback on their care. We received 315 pieces of feedback; positive comments focussed on the caring nature of staff, mixed and negative comments had clear themes of stressed and uncaring staff, particularly on the postnatal ward where women and birthing people would have liked more support with caring for and feeding their babies. Several comments mentioned delays to care and receiving pain killers, state of the environment, and communication breakdown.

There was a Maternity Voices Partnership (MVP) to encourage community engagement in improving services. The MVP chair told us that regular meetings took place monthly. However, attendance had been slow to recover post-COVID, and engaging with all members of the area's diverse population was a challenge. In February 2023 and March 2023, two service users attended each meeting. However, the MVP chair told us that service leaders were welcoming, open to MVP suggestions and feedback, and inclusive to MVP members. The chair told us that interactions were positive, and staff were committed to providing the best care possible to women and birthing people in the area. Women and birthing people in Tooting could access the MVP via internet and email, which may exclude more vulnerable population groups.

The service ran patient information sessions called 'ask the anaesthetist' and evaluation and feedback from attendees was positive.

In the 2022 maternity survey, the service performed well in questions about communicating with healthcare professionals and had made significant improvements in postnatal care including information sharing with GPs for the benefit of women and birthing people, access to midwives, and partners being involved in care and able to stay in hospital for support.

An in-house maternity outpatient survey was completed in February 2023. Out of 37 respondents, 11 (29%) reported being seen on time, and those experiencing delayed appointments were not told. It was not clear what the service was doing to improve this. The service carried out regular patient satisfaction surveys and women and birthing people who used the service were mostly positive and reported being cared for by staff with kindness. Maternity services consistently scored in the trust's highest performing departments in patient satisfaction surveys.

We saw staff email communications with positive news and updates about the service however, staff we spoke to told us that there was not always time to read and respond to email communication, and it was not clear if these messages were shared in other ways. Ward managers and staff had introduced QR codes for women to easily access information and provide feedback. Staff had interpretation services available to them for women and birthing people who do not speak English, and they knew how to use them. However, the local population comprised of many different nationalities, and we found incidents when interpreters had not been used, which had contributed to poor experiences and outcomes for women.

Learning, continuous improvement and innovation

Maternity

All staff were committed to continually learning and improving services. They did not always have a good understanding of quality improvement methods and the skills to use them. Audit results were not actioned and used to inform and improve care. Leaders encouraged participation in research.

During the inspection we saw audits were completed however, poor compliance at audit was not always acknowledged or acted upon. There was no evidence to support effective audit cycles to be completed in order to drive change and monitor improvement over time. Incidents and investigations were not categorised appropriately or managed in a timely way, and this impacted the services' ability to learn and improve. We saw maternity reports to the board and divisional governance meetings did not set out clear plans of improvement and learning within the service.

During the factual accuracy process, the service told us a maternity quality improvement (QI) team had been in place since January 2021 with support from the trust QI team. The service told us some staff had been given QI training, and the maternity helpline was an example of the team's work.

The service had signed up for the Capital Midwife leadership programme, designed to support midwives from ethnic minority groups into leadership roles, which was a positive step in equality and representation for service users and equal staff opportunities. However, staff we spoke to were unaware that the service was participating or had enrolled staff on the programme. During the factual accuracy process, the service provided evidence that staff had been emailed to inform them of the scheme.

The service specialist midwife for haemoglobinopathies received a midwifery practice trailblazer award for her work with sickle cell disease in pregnancy in February 2023. There was a well-developed haemoglobinopathies service for affected families and out-of-area referrals were accepted for pregnancy diagnostic testing. The screening service collected relevant equality and diversity data, and demographic information in order to tailor services according to the local population.

Obstetricians ran in depth training sessions for medical staff looking at complex case histories in order to learn and improve.

Midwifery leaders and other staff had attended webinars covering advanced midwifery practice.

The service had implemented a maternity workforce programme in conjunction with a nearby university to upskill maternity support workers and a competency framework was produced. The service aimed to encourage other trusts to enrol on the programme and share resources and knowledge.

The service was involved in research programmes and has published articles on COVID-19 and pregnancy hypertension carried out at the hospital. Other research programmes include topics such as twin pregnancy, optimal gestation for birth in late onset growth restriction, rare diseases, group B streptococcal infection, and many others.

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.

Maternity

St George's University Hospital maternity services

Action the trust MUST take to improve:

- The service must ensure staffing levels are safe and there are effective processes in place to escalate and mitigate safe staffing concerns. (Regulation 12)
- The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))
- The service must ensure adequate and up-to-date policies, pathways and guidance are in place, including implementation of a standard operating procedure in maternity triage and clear, effective escalation pathways to mitigate for risks of short staffing on women, birthing people, babies and staff. (Regulation 12)
- The service must ensure safe care of women in labour especially in relation to fetal monitoring. (Regulation 12 (2) (a) (b))
- The service must ensure that all staff groups complete mandatory training in a timely way. (Regulation 12)
- The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))
- The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments. (Regulation 12 (2) (g))
- The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))
- The service must ensure clinical areas are clean, fit for purpose and equipment is properly serviced and maintained in a timely way, including but not limited to emergency trolleys, resuscitaires and appropriate, timely portable appliance testing. (Regulation 15 (1) (a) (c) (d))
- The service must ensure governance processes are effective including but not limited to communication between staff, service leaders and trust executives, clear and up-to-date guidelines in place, acting on audit results, and appropriate incident management. (Regulation 17 (1))
- The service must ensure all staff are provided with annual developmental appraisals. (Regulation 12)
- The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))
- The service must ensure maternity safeguarding processes are strengthened, including timely staff training, consideration of a maternity safeguarding policy, adequate availability of staff trained in safeguarding concerns, and timely actions to implement safe measures to reduce the potential for baby abduction. (Regulation 13)
- The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12)
- The service must ensure that documentation in the bereavement suite is completed contemporaneously and in full. (Regulation 17 (2) (c))

Action the trust SHOULD take to improve:

- The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies.

Maternity

- The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way.
- The service should ensure it takes account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups.
- The service should formalise a second consultant ward round on the labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations.
- The service should examine its culture and involve staff in improving it, including staff members with protected characteristics under the Equality Act 2010.
- The service should improve executive knowledge of and involvement in maternity services, including but not limited to growth of the maternity safety champion role, and health inequalities for women and birthing people who use the service.

Following our inspection, we served a warning notice asking the trust to make significant improvements in the timely and effective triage of women and birthing people, timely response and maintenance of structural or equipment issues, safe levels of staffing, and governance and oversight of the service. The service was required to submit an action plan, and we will continue to monitor progress in relation to this.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 CQC team inspectors, 3 midwifery specialist advisors, an obstetric specialist advisor, and was joined by a CQC national clinical advisor who observed the inspection. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.