Guy's and St Thomas' NHS Foundation Trust

St Thomas' Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at St Thomas' Hospital

Good 

We inspected the Maternity service at this location 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 will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the Maternity service, looking only at the safe and well led key questions.

Our rating of this maternity service stayed the same. We rated it as Good. We rated safe as Requires Improvement and well-led as Good.

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.

Guy's and St Thomas' Hospital NHS Foundation Trust provide maternity services at St Thomas' Hospital and local community services. The maternity service has over 6000 births per year, 6000 NHS births and 300 private patient births.

- Antenatal Clinic
- Antenatal Ward
- Community Midwifery
- Fetal Medicine Unit
- Home from Home Birth Centre
- Hospital Birth Centre
- Maternity Assessment Unit
- Triage
- Post Natal Ward
- Westminster Maternity Suite (private wing)

Maternity

Good  

Our rating of this location is Good because:

- Staff had training in key skills. They worked well together for the benefit of women. They understood how to protect women from abuse. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Managers made sure staff were competent. Most staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services, and staff were committed to improving services continually.

However:

- The service did not always have enough staff to respond to, and support mothers and babies.
- Women could not always access the triage and maternity assessment unit when they needed it. They often had to wait a long time to be triaged, for a medical review or to be admitted or treatment.
- The environment in triage and the maternity assessment area meant staff could not always maintain women's privacy and dignity.
- Records were not always stored securely.
- Following our inspection, we received 268 feedback forms from women who had recently used maternity services at the hospital. Six out of 268 reported a positive experience, 79 out of 268 reported mixed feedback, and 183 reported negative feedback.
- Negative feedback was generally related to women not feeling listened to in labour, feeling pressured to have an induction of labour, inadequate staffing numbers and waiting times in the triage area.

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and had a process to help ensure everyone completed it.

Mandatory training was a training requirement determined by the trust and women's services through policy. It was compulsory for staff to attend all training relevant to their role.

Maternity

Face-to-face training had changed to virtual training during the start of the COVID-19 pandemic. They had used a range of tools to ensure it was still interactive. This included jam-boards, videos, break out groups and staff quizzes. Face to face training had resumed, although some sessions were designed using a hybrid model. This was in response to staff feedback.

Training compliance was below the Trust target of 95% and was affected by the significant operational challenges. This was initially in response to the COVID-19 pandemic and currently due to subsequent staffing pressures. Training compliance was reported and monitored through the maternity dashboard. Average compliance rates for mandatory training were broken down into each clinical area. None of the areas had met their compliance target of 95 % and rates varied from 78% for postnatal ward staff, to 87% for antenatal clinic staff.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training included but was not limited to: fire safety, equality and diversity, information governance, and emergency skills and drills.

Annual cardiotocograph (CTG) training was mandatory for all midwifery and obstetric staff. Learning to support fetal monitoring was also supported during weekly meetings to discuss recent cases of interest. They were also required to complete an assessment following training to ensure they were competent to interpret CTGs. Ninety nine percent of midwives had completed the training and assessment, 97% of postgraduate doctors and 95% of consultants. Staff were given one-to-one support if they had to re-take the assessment. Evidence showed all staff had passed their assessment.

Compliance rates for PROMPT (practical obstetric multi-disciplinary training), was 95%. Training was multi-disciplinary to improve time spent together and team building. Live drills were performed in all areas of the unit and involved the multidisciplinary team. Human factors were weaved into all training to maintain their safety culture.

The design of training was responsive to staff needs and used innovative techniques. This included live drills in the community with the ambulance trust. They also used scenario role play in their simulation centre. The role play sometimes included professional actresses. A video feed was used to film participants involved in role play. Attendees could observe their practice in the video play- back. The practice development midwives (PDMs) used the video to facilitate a debrief that considered clinical and human factors.

They included extra study sessions for staff who had trained during the pandemic and consequently missed some training sessions. They considered the impact of staff who had trained during the pandemic and supported them accordingly.

Drills were organised when it was considered clinically safe to do. They made sure they did not compromise care. Drills were followed by a facilitated de-brief of all participants. This helped to identify areas for development.

The PDMs managed training timetables and ensured capacity was available to meet the demands of the organisation. They used link and external trainers where appropriate. They worked with managers to ensure sessions were available at appropriate times and produced annual timetables in good time. This enabled managers and staff to plan and book training and offer some additional sessions as required.

Managers were notified of non-attenders by the PDMs. Staff were offered another date, if staff failed to attend again this was escalated to the management team. The training database for obstetric staff was reviewed quarterly by the service lead for obstetrics. Any non-attenders for the past 12 months had to re- book onto the next junior doctors' induction or midwifery training session. Managers made sure staff attended mandatory training.

Maternity

Safeguarding

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

Maternity staff received training specific for their role on how to recognise and report abuse. The service had a safeguarding team. They were trained to safeguarding level 4. All midwives and obstetric staff were trained to safeguarding level 3. All maternity support workers and theatre staff were trained to safeguarding level 2.

Training included a general update on domestic abuse, ill mental health, their homeless pathway, risk assessments and how to make referrals. Baby abduction drills were included in their skills and drills programme.

Specialist and community teams received regular one-to-ones and group safeguarding supervision. Ward midwives received regular safeguarding advice and supervision at daily ward huddles and rounds. They were assured that all staff had access to support with safeguarding matters.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff discussed safeguarding concerns at every handover in all clinical areas. The multidisciplinary meetings and sharing of information helped to ensure they interacted and coordinated their efforts to diagnose, treat and plan for vulnerable women and families.

The safeguarding team worked closely with the social work and mental health teams aligned to the trust. They liaised with outside agencies to support discharge planning for mothers with safeguarding concerns.

Staff did not record safeguarding concerns in women's handheld notes. This was because it could place them at risk. Staff recorded safeguarding concerns on electronic records, accessed by those who needed it. A flag was raised on the woman's record to alert staff and ensured they were aware of the concerns.

They had seen an increase in the number of women reporting domestic abuse during the pandemic. The safeguarding team provided regular updates on domestic abuse, as part of mandatory training days. Staff recorded enquiries, disclosures and referrals about domestic abuse in a way that hid it. This was to ensure perpetrators could not access this confidential information.

We checked the notes of five pregnant women. They were all routinely asked about their mental health. They were all asked about domestic abuse on more than two occasions in pregnancy and following birth. They were assured midwives were identifying women in abusive relationships to support them and their unborn baby to stay safe.

Cleanliness, infection control and hygiene

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

The premises were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated the service performed enhanced and more frequent cleaning of all areas to prevent the spread of COVID-19, in line with national guidance. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Maternity

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of PPE which was stored on wall mounted displays. Overall compliance for staff using the correct PPE was 95.8% in September 2022.

Hand sanitiser gels were available throughout the service. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks Staff were bare below the elbow and washed their hands appropriately.

Hand hygiene audit results were completed for all clinical areas. Results for June -August 2022 varied between 85% for the home-from-home birth centre to 100% for the fetal medicine unit, the Westminster maternity suite and postnatal wards.

There was no sluice in the triage area. Staff tested urine samples on a clinical trolley in an open area that was used by staff, and members of the public. We highlighted this to senior staff who told us the area had a risk assessment by the infection prevention and control team. We did not see the risk assessment.

Environment and equipment

The design of triage did not always follow national guidance and the environment meant women's privacy and dignity could not always be maintained. The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff managed clinical waste well.

The midwifery assessment unit (MAU) was open 24 hours a day. It included a day assessment unit and an emergency assessment service known as triage. The service was for women from 18 weeks of pregnancy and up to 6 weeks postnatally. Women attended with planned and unplanned appointments. They also attended for assessments to determine if they were in established labour.

There was no dedicated waiting area and women waited in a corridor, outside the clinical area. This included women attending for a labour review. The seats were office-based chairs which could be uncomfortable for women in labour, and the area was very congested at the time of our visit. The environment was not suitable for women who could be in labour. The environment meant it was difficult for staff to maintain women's privacy and dignity.

The hospital birth centre included two theatres for planned and emergency caesarean sections and other obstetric surgical procedures. The service had identified the need for an additional theatre to accommodate additional surgical activity. We were told there were occasions when both theatres were in use when a woman needed an emergency caesarean section. The serviced had to use an anaesthetic room on these occasions.

However, this room was not fit for purpose. It was difficult to get all the required equipment into the space, and the room was very close to the corridor. This was recorded on the maternity risk register and had been reviewed on two occasions in September 2022. Senior management were scoping the feasibility for an additional theatre but using the anaesthetic room had not mitigated the risk.

Short term mitigation had been to expand planned caesarean section lists to 6 days a week, Monday to Saturday (rather than Monday to Friday). The main theatres in North Wing were also used for some of the more complex surgery for women with high complex care needs, such as maternal cardiac disease. These short-term mitigations had also reduced the clinical demand for the maternity obstetric theatres.

Maternity

The hospital birth centre had a specific suite for women and families who had experienced a baby loss, called the Butterfly Suite. The area included two dedicated bereavement rooms in a secluded area, with a separate entrance. It was located away from the birth centres so that it offered families a private and comfortable space to grieve the loss of their baby

The Butterfly suite was staffed by the hospital birth centre team, supported and managed by the bereavement team. The bereavement team managed the service, led on bereavement training and supported the hospital birth centre staff to care for bereaved families. The service had a bereavement support team as recommended by the stillbirth and neonatal death charity (SANDs) best practice; Five ways to improve care for parents whose baby dies before, during or shortly after birth (2016).

The Butterfly suite was refurbished in October 2020. This was funded by Guy's and St Thomas' Charity. Bereaved families were involved in the refurbishment and helped to influence the design. The suite was decorated in a sensitive way. It featured butterfly themed artwork which was chosen by families who had been affected by baby loss. Both rooms included a fold-out bed for partners, food storage, and refreshment facilities. Rooms included cold cots and cuddle cots, a memory box for parents to make special keepsakes and spend precious time with their babies.

The Trust partnered with the baby loss charity Petals to provide six free counselling sessions. This was funded by Guy's and St Thomas' Charity to help individuals, or couples process the grief they had experienced. They could also support them through future pregnancies. They also worked with the charity Cradle to provide parents dealing with early pregnancy loss with peer support, comfort bags and outpatient support packs.

All labour/birthing rooms on the hospital and home-from-home birth centre were ensuite. Doors did not display vacant or engaged signs, but we observed staff knock and wait before entering.

There were 13 labour/birth rooms on the hospital birth centre. Each room included a computer so staff could maintain contemporaneous notes, without leaving women. Each room also contained a cardiotocograph (CTG) and infant resuscitaire. They had enough suitable equipment to care for high and low risk women during labour and birth.

The home-from-home birth centre was designed for women who were low risk. They had eight labour/birth tooms. Two rooms had a pool for labour and birth. There were two resuscitaires and emergency equipment situated within easy reach of each room. Every room had a resuscitaire area and equipment They had enough suitable equipment to care for low-risk women during labour and birth.

The home-from-home birth centre was situated next to the hospital birth centre. This meant women could be quickly transferred if they developed complications. The neonatal unit was also nearby in case a baby needed to be transferred.

Managers ensured all specialist equipment was serviced and calibrated. They maintained oversight of equipment to ensure it was safe and ready for use. We checked 30 pieces of equipment and saw evidence of up-to-date safety testing. Consumables were stored securely and were all in date. Records demonstrated staff carried out daily safety checks of specialist equipment.

Equipment was provided to assist staff with the safe evacuation of a woman from the birthing pool. The service provided training in how to use the equipment. This included a training video developed by the practice development midwives. Staff showed us how they would evacuate a woman in an emergency. They were familiar with the procedure and would be ready in this type of emergency.

The resuscitation trolley was stored on the high dependency unit because this area was central to all other areas in maternity. All clinical areas had an emergency trolley for obstetric emergencies. We checked the emergency trolley in triage and the postnatal ward. There was evidence that daily checks had been completed to ensure all items were present and in-date.

However, audit results for daily safety checks of resuscitaires were 63% in June and 83% in August 2022. The service had implemented safety actions to improve compliance. This included the introduction of a new daily midwifery practice lead midwife checklist. This was to ensure all resuscitaires had a daily check to ensure they were clean, stocked and suitable for neonatal resuscitation.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Sharps bins were no more than three-quarters full. The date opened was stated on the bins and within three months of expiry in all areas. Arrangements for control of substances hazardous to health were adhered to. The sluice was not locked on the hospital birth centre, but all cleaning equipment was stored securely in locked cupboards.

Assessing and responding to patient risk

Staff completed risk assessments and updated them for each woman in pregnancy and took action to remove or minimise risks. However, they did not always identify and quickly act upon women who attended triage and were at risk of deterioration.

We reviewed five maternity care records. The lead professional was confirmed in all of them. Risk factors were highlighted. For example, women with a high body mass index, living in a deprived area, or comorbidities. Women were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

Carbon monoxide screening was performed in each set of notes reviewed in line with best practice guidance. Staff risk assessed every woman's risk of venous thromboembolism at booking, on arrival in labour, and during post-natal care. This was in line with national guidance.

Staff monitored the baby's growth, and accurately plotted this. Staff identified babies that were not meeting their growth potential, as they would be at higher risk of complications. Women were screened for safeguarding concerns and staff used the information to plan care and involve the right staff.

Staff ensured women understood the importance of vitamin D supplementation and monitoring their baby's movements from 25 weeks of pregnancy.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. Staff completed and recorded MEOWS observations electronically.

Women who chose to give birth outside of guidelines were supported. They were offered an appointment with a consultant obstetrician and/or an appointment with a consultant midwife. The consultant midwife discussed the woman's decision, and they agreed a birth plan. The aim was to support their choice and ensure everything was planned to ensure the birth was as safe as possible. Midwives told us the teams worked together well to support informed choice. Midwives felt well informed and well supported in these situations

Maternity

Staff shared key information to keep women safe when handing over their care to others. They used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members. An electronic SBAR handover form was used. They discussed key information about women's pregnancy, labour or postnatal information. This also included information of concern. For example, safeguarding concerns, and information about their wellbeing and support from partners and family.

Safety huddles took place in each ward or area and included necessary information to keep women and babies safe. There was an overview of staffing and acuity across the unit. High risk antenatal women who were in-patients were discussed and women waiting for induction of labour. Some safeguarding issues were highlighted which could be clinically relevant. The handover also included a discussion about high-risk women. Staff were encouraged to contribute, and there was effective communication and shared learning.

We randomly reviewed three cardiotocographs (CTGs). Only one had fresh eyes completed hourly. Fresh eyes mean a midwife or obstetrician reviews the CTG every hour with a colleague, to reinforce good practice and help with decision making.

Two CTGs showed intervals of 4-6 hours without a fresh eyes review. Audit of compliance with 'fresh eyes' was completed in July 2022. Ten sets of notes were reviewed and only two had 100% compliance to 'fresh eyes'. This was not in line with local and national policy.

Managers did not effectively monitor waiting times for the midwifery assessment unit (MAU). This included the triage area. Women were frequently not reviewed within agreed timeframes and national targets. Staff told us women often had long waiting times for triage, assessment and an obstetric review, if required. The MAU was very busy when we visited, and staffing numbers were below their establishment.

MAU was the first point of contact for women in labour or with pregnancy related concerns. Women were encouraged to call MAU prior to attending and could self-refer without making contact. National guidance advocates consideration of assessment by telephone triage provided by a dedicated triage midwife for all women (NICE, 2017).

However, the phone-line did not always have a dedicated staff member to triage the calls. Also, the line did not automatically divert to an alternative number or voicemail, if calls were not answered. This meant women often attended unannounced. It was difficult for staff to manage the flow and ensure women were triaged and reviewed in a timely way to ensure women were prioritised according to their risk and need.

We reviewed the number of incidents reported in the past six months for triage. Twelve were reported due to delays in women being triaged and or reviewed, due to acuity or staffing shortages. The risk team told us triage and MAU generated the most incident reports. They ran monthly cross- checks to ensure all issues had been reported and gave staff feedback even if they had not completed the incident report to highlight an issue.

The service completed a fact-finding exercise related to triage/MAU in April 2022. This was to get a 'snap-shot' of activity, busiest periods, most common reasons women attend, wait times, feedback regarding women's experience and staff experience of working there.

The exercise identified concerns related to waiting times, efficient flow and issues regarding the suitability of the environment for women attending. The service had implemented staggered shift patterns for midwives to reflect peak

attendance times. They appointed a new midwifery matron on 3 October 2022 (shortly after our visit). They were appointed to provide further midwifery leadership within MAU. The trust also appointed 4 obstetric clinical fellows to MAU shortly after our visit. They were appointed in September 2022 to provide medical presence and cover from 9am to 9pm.

Midwifery Staffing

The service did not always have enough maternity staff to respond to and support mothers and babies. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

Midwifery and maternity support worker vacancy rates were added to the maternity risk register on 24 September 2020. This risk was initially recorded as a result of COVID-19 related shortfalls. The risk remained current due to their vacancy rate, a high attrition rate, difficulty in recruiting experienced staff and challenging maternity safety and quality targets. There had been 55 incidents reported in the previous six months in response to safe staffing concerns.

The service monitored the vacancy rate closely through their maternity dashboard and were actively recruiting additional staff. This included participation in the Capitol midwives' scheme for international recruitment.

The service had up-to-date policies in escalation and closure of the unit to support staff and ensure senior managers and clinicians were informed and involved during periods of high acuity and activity. Arrangements were embedded to call on general nursing staff to support with care that was not midwifery specific. For example, to provide post-operative care to women following caesarean sections.

Managers ensured women received one-one care in labour. There were always two coordinators working on the hospital birth centre. This ensured one was supernumerary and able to maintain a helicopter view of the area. The other coordinator held the bleep for the unit and could move staff to areas most in need. They monitored compliance to the supernumerary status of the coordinator.

Maternity staffing levels were discussed at all safety huddles. Additional safety huddles were called as required. Senior midwifery staff attended the safety huddle if an escalation occurred. The coordinator triggered the escalation process if staffing numbers were unsafe and spoke with the site nurse practitioners to keep them informed of the situation.

Safe staffing in maternity was regularly reported to the quarterly public trust board meeting. The trust had completed a recruitment and retention plan. This included a review of their maternity support worker establishment, roles and banding. This was aligned to the Birthrate plus recommendations for midwife to support worker ratio and improve the quality of experience for women and families.

The service made sure staff were competent for their roles. Practice development midwives (PDMs) were responsible for ensuring any concerns with staff competence were effectively escalated to their line manager. PDMs worked with line managers to support staff when competence issues were identified.

The Professional Midwifery Advocates (PMAs) were responsible for implementing the A-EQUIP Model (advocating and educating for quality improvement). This model aimed to support midwives through a process of restorative clinical supervision and personal action plan, for quality improvement. Midwives had access to support from their PMAs and were encouraged to meet them when training needs were identified.

Managers gave bank staff a full induction and ensured they completed all mandatory training. New starters had to complete a two-week induction programme. Their competencies were assessed and signed off during this period. They were supervised and supported by the practice development team. They made sure staff had the clinical skills to keep women safe.

There was a preceptorship programme for newly qualified midwives to progress from a band 5 to band 6 grade. The preceptee programme supported band 5 midwives with 6 weeks supernumerary shifts and training days over the first year. This included 4 weeks induction and 2 weeks at each change of clinical placement.

The programme adopted a blended learning approach. It included study days, electronic learning modules and reflective sessions. The learning supported their transition from student to qualified practitioner. Newly registered staff were appointed a preceptor by their line manager. The preceptor acted as a professional role model and supported their learning and development throughout the first 12 months of their career.

Managers supported staff to develop through yearly, constructive appraisals of their work. We were given examples of how staff had been supported to develop. One midwife had recently been supported to complete the newborn and infant physical examination course. A midwife on the postnatal ward had been supported to complete the family planning course. Staff were given opportunities for development as part of their annual appraisal.

Medical staffing

The service did not always have enough medical staff deployed to triage women to keep women and babies safe from avoidable harm, and to provide the right care and treatment. Medical staff received good supervision and support.

Women attending triage often did not have timely medical reviews as medical staff also provided cover for the hospital birth centre. The consultant cover was provided by the consultant covering the elective caesarean section lists This meant waiting times were unpredictable because medical staff had other work commitments which took priority. Waiting times often exceeded expected timeframes and national guidance.

Consultants were on site 8.30am to 10.30pm and on-call 10.30pm to 8.30am, 7 days a week. They completed two ward rounds on the hospital birth centre, one in the morning and one in the evening. However, the service was not adhering to recommendations outlined in Safer Childbirth (2007), and Standards in Maternity Care (2016), by providing 168 hours of consultant presence by 2008.

The ward rounds were attended by obstetric, anaesthetic, midwifery staff and students. The consultant led the round, and they were used to review and plan women's care and for sharing learning with the rest of the team. The primary midwife gave the team a verbal handover outside the room. The consultant only reviewed labouring women if it was clinically indicated and the rest of the team waited outside. Staff considered women's privacy and dignity in labour.

Junior doctors and midwifery staff told us consultants were visible, available and supportive. There was no hierarchy. They were encouraged and supported to professionally challenge clinical decisions. There was an emphasis on learning and improvement and supporting colleagues. The service recognised the attendance of consultants at multidisciplinary training and meetings was imperative to create and maintain good working relationships throughout the department.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The training database was reviewed quarterly by the service lead for obstetrics and gynaecology. They maintained oversight to ensure staff were up-to-date. Their licence to practice would be affected if they did not complete mandatory training. However, one member of staff told us their rota co-ordinator was also their college tutor which could be a conflict of interest.

Records Staff kept detailed records of women's care and treatment. Records were clear and up-to-date. However, they were not always stored securely or easily available to all staff providing care.

Records were not always stored securely. We saw there was a lock on the door on the staff room on the postnatal ward, but the room was kept unlocked. We also saw the computer screen was left unlocked with the ward handover details on display. The computer screen was also unlocked in the neonatal room. Some antenatal and postnatal notes were paper based. Paper records were stored in an unlocked trolley on the postnatal ward. Confidential information could be accessed by non-clinical staff and members of the public.

Staff kept records of women's care and treatment. The maternity service mostly used electronic records. The discharge process was electronic. We checked five sets of maternity notes and saw they were all dated, timed and signed. The service used electronic prescriptions, which included details of the woman's weight and allergies. Potential safeguarding issues were flagged electronically so all clinicians could recognise and act on safeguarding concerns.

Women's notes were comprehensive, but staff could not always access them easily**.** Staff also had difficulty accessing the electronic MEOWS chart which staff used to review early signs of maternal deterioration. Staff told us this was because there were different systems for pathology, admissions, medicines and maternity records, However, the trust had commissioned a new IT system to be implemented in March 2023. This would help information be more easily available.

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, the storage of some medicines was not safe.

Staff followed systems and processes to prescribe and administer medicines safely. They received mandatory training in medicine management every year. Obstetric staff were required to complete this training within three months of employment in order to be able to prescribe medication. Their training compliance for women's services was 96.7% in September 2022.

Staff completed medicine records accurately and kept them up-to-date. The maternity service used an online prescribing and administration system for maternal prescriptions. We reviewed the medicine records for four women. Prescriptions were legible, named, dated, allergies and weight were clearly documented, and administration and route of administration were also clearly recorded.

Medicines were managed through a digital system. The electronic system sent reminders using an alert, when medicines were due. It also checked the dosage of dispensed medication.

Records for checking controlled drugs demonstrated that the medicine policy was followed. Records showed two staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

There was a dedicated pharmacist for maternity services. They completed daily visits of clinical areas and were available for support and advice with medicine matters

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

However, the emergency trolley on the maternity assessment unit was not locked. The trolley contained intravenous fluid and drugs to use in emergencies. We also saw some ampules of drugs in an unlocked drawer on the home- from-home birth centre. We highlighted this immediately to senior staff. Senior staff told they returned the MAU emergency trolley to the locked MAU clinical room as soon as they were informed.

Fridge temperatures were checked to ensure the fridge temperature was maintained between a minimum and maximum recommended temperature. However, they were not always checked daily. This could mean that medication was not always stored at the correct temperature. which could affect the efficacy of medication.

However, the maternity service recently joined the trust ward accreditation monitoring process in September 2022. This provided peer review and enhanced monitoring of compliance with fridge temperature checking.

Incidents

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

Staff knew what incidents to report and how to report them. There was a clear process which all staff we spoke to understood and followed. The trust used an electronic reporting system which all grades of staff had access to. Everyone understood their responsibility to report all incidents that they felt could affect safety

Managers debriefed and supported staff after any serious incident. We were given several examples of how staff had been supported. The service employed a full-time clinical psychologist for women’s services. This was in recognition of the fact that staff were often exposed to or involved with traumatic events.

Staff received a hot debrief immediately following an incident. Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event and has the advantage of earlier intervention, improved participation and improved recall of events. The process for investigating and managing incidents was based on learning and improvement, not or apportioning blame.

Staff felt well supported by colleagues, management and the wider team when they were involved in an incident. They received swift support and were given options. In addition to their team and line manager this could include their clinical psychologist, professional midwifery advocate or manager.

Staff with different roles and grades gave recent examples of how they had felt well supported following a clinical incident. Mangers and midwives in charge of shifts also considered colleagues wellbeing, especially when they had worked a difficult shift. Psychological support and safety were routinely considered as part of investigations into clinical incidents.

Maternity

Staff received feedback following incident investigations and themes from incidents were shared. There was a staff update board in all clinical areas. This included a variety of clinical information to update staff. For example, themes from incidents, learning identified, and good practice was highlighted. It also included reminders about key changes to guidance or practise. Themes were also shared to all staff groups by email and summarised in a monthly quality newsletter.

Learning from incidents was shared at handovers and huddles in all clinical areas. This was known as the 'Big Four'. Four safety messages were shared with all staff. Safety messages were updated weekly. For example, at the handover on the hospital birth centre staff were reminded of the importance of using blood spillage kits, wearing aprons and eye protection for all births, ensuring they read the staff information boards, and the process to follow a needlestick injury.

There was a panel review process to ensure external staff with expertise were involved in investigations. Women were involved in investigations and had a point of contact, so they had continuity and support throughout the process.

Staff understood the duty of candour (DoC). They monitored their compliance to DoC through audit and results showed they were open and transparent and gave women and families a full explanation when things went wrong. They assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.

The senior leadership team was formed of a chief midwife, clinical director, deputy chief midwife and general manager. The chief midwife and deputy chief midwife had been in post since January 2022 and provided a clear link to the clinical group executive team. There was a clearly defined management and leadership structure in place. We were told of joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The chief midwife was supported in their role by the deputy chief midwife. The team was also supported by four lead midwives, two consultant midwives, five midwifery matrons and band seven lead midwives. Some of these appointments were recent and the roles were new and yet to be fully embedded.

Maternity

In line with 'Spotlight for Maternity' (2016) the maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board and or the executive team. The chief midwife attended board meetings. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies and the need for an additional obstetric theatre.

Staff told us senior managers were visible and available. They completed daily walk-rounds of clinical areas. There were five safety champions for maternity services. They also completed regular walk arounds. Staff found them approachable, and keen to hear their views and experiences, to drive improvement.

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.

There was a trust wide strategy for nursing and midwifery for 2022 – 2025. Their vision was to empower nursing and midwifery excellence through a compassionate and inclusive culture that maintained their trust values. The strategy had five strategic priorities and outlined how they would achieve their aims.

The Steering Group would evolve into the implementation group to oversee the implementation of the strategy through measurable objectives. There was a plan for all objectives to have a named lead(s)

Implementation of the plan would be reported to the nursing and midwifery executive committee. Directors of nursing would provide a clear link to the clinical group executive team.

Culture

Staff mostly felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear. However, we identified negative themes related to women's experience following our visit.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff told us they were proud to work for the trust.

They described healthy working relationships where they felt respected and able to raise concerns without fear. We were given several examples of how staff had felt able and supported to professionally challenge clinical decisions. This included junior members of staff. Staff told us the culture was one of learning, not blame. However, three members of staff told us management did not address concerns about staff who could be challenging. They felt there was gap between acknowledging their concerns and acting on them.

The trust employed three Freedom to Speak up Gradians (FTSuG), to support staff who wished to speak up about a concern or issue. The FTSuG were not employed directly by the maternity service. They ensured any issue raised was listened to and feedback was provided to them on any actions or inactions because of them raising an issue.

The FTSuGs were involved in mandatory training, to raise awareness about their role and how they could support staff and the escalation process. However, although staff were aware of the safety champions, not everyone was aware of the FTSuGs, their remit, or how to contact them.

All staff received training in equality and diversity. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff felt there was a more proactive approach to this in the last six months. This was also reflected in senior appointments and promotion opportunities.

Management considered flexible working requests, career breaks and special-leave requests. We spoke with a midwife who was about to take a 12-month break to spend time overseas. The trust had implemented extended phased returns and the trust board had given all maternity staff an additional annual leave day. This was in recognition of their hard work throughout the pandemic.

There was a commitment to safety, learning and improvement, which, required a firm commitment to supporting staff through induction, training, and processes of review. This created a culture of learning and improvement rather than defensiveness and blame.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas. Their average number of monthly complaints were 11. They looked at themes from complaints and tried to identify the root cause.

Leaders told us complaints were often related to concerns that staff were unhelpful. They felt this was often because staff were working in areas where they were not able to give women the right information. This was because they had been moved, due to acuity.

Staff could give examples of how they used women's feedback to improve daily practice. For example, women fed back that they wanted their partners to be with them when they experienced complications.

Managers shared feedback from complaints with staff and learning was used to improve the service. Themes were shared at handovers, huddles, on staff notice boards governance newsletters and emails.

We spoke to 12 service-users during our visit. They were all happy with their care and experience. However, we also received 268 feedback forms from women who had used maternity services following our inspection. Six out of 268 were positive, 79 provided mixed feedback, and 183 were negative.

There were common themes within the negative feedback. Themes included concerns about short staffing numbers throughout the whole maternity department and especially the triage area, where long waiting times were a general concern. Themes also included women not feeling listened to by staff in labour, negative staff attitudes and feeling pressure to be induced.

Maternity services collected and monitored user feedback. Results for the Friends and Family Test for April to June 2022, showed an overall positive response rate of 93.6% to 94.4%.

The service had developed a maternity experience improvement action plan in January 2022. The action plan aimed to improve care and experiences for women and families. The maternity services clinical group and the trust board acknowledged the negative feedback we received from women and their families. We were reassured the feedback would be prioritised in order to improve the experience for all women and families.

Maternity

Governance

Leaders did not always operate effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, they did not always have oversight of audits and not all guidelines were up-to-date.

Information was captured and used to monitor the quality of the service provided. The maternity dashboard captured information on workforce, maternity morbidity, perinatal morbidity and mortality, readmissions, maternity safety, test endorsement and public health data.

This information was reviewed at the maternity clinical governance meetings. Some information was also presented in the trust integrated performance report. This was reviewed by the board and executive team. Specific maternity papers relating to national schemes and reports such as the maternity incentive scheme and Ockenden reports (2020, 2022) were presented to the board. Staff were able to access information to help them form a judgment about the quality of the service.

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. There was a team, whose prime responsibility was to support clinical governance. They reported to the deputy chief midwife.

There were clearly defined reporting avenues. Incidents, risks, performance, guidelines, audits and user experience were discussed at service governance meetings. These fed into divisional meetings which then escalated to trust wide committees through to the subcommittees of the board.

Maternity services had a quality improvement project (QIP), programme for 2022-2023. This included approved quality projects, national and local audits and service evaluations. They participated in four national audits which included national pregnancy in diabetes audit, national maternity and perinatal audit and the UK obstetric surveillance survey. They participated in the national confidential Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK.

They had five service evaluations planned for 2022/23 which included an evaluation of their out-patient induction of labour service and their perinatal health service.

Maternity services had approximately 106 guidelines. This included approximately 25 that were out-of-date. The service received an alert when guidelines were due for review and prioritised any guidelines that needed updates to reflect national guidelines. However, the COVID-19 pandemic had impacted on their capacity to ensure all guidelines were up-to-date. Staff might not always be following up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

National guidance advocates consideration of assessment by telephone triage, provided by a dedicated triage midwife for all women (NICE, 2017). However, staff working in the midwifery assessment unit and triage area were often unable to answer the telephone. This could be due to staffing issues and/or high acuity. The telephone-line did not automatically divert to an alternative number or to voicemail if calls were not answered. This made it difficult for staff to manage the flow and acuity in the triage area. This was not in-line with national guidance and best practice.

Maternity

Staff were unable to effectively monitor triage times because the time of arrival and time of triage were not mandatory fields on their IT system. Staff were unaware of any audit of triage waiting times and reviews. The oversight of triage flow was not effective. This made it difficult to determine if women were seen and treated according to their clinical urgency and need.

Managers monitored daily staffing numbers closely during a daily Sitrep meeting. This had been implemented in August 2020. The meeting was used to provide oversight of activity and staffing in the maternity unit and community midwifery service. It was used to pre-empt and address safety concerns.

We highlighted unsafe staffing levels during our visit to the triage area. Staff had not triggered the escalation policy, but more staff were re-deployed in response to our concerns. This meant staff had been unable to use their triage tool within the recommended timeframe to define clinical urgency, guide timing of subsequent assessment and immediate care.

There was a monthly audit meeting and their audit sub-committee met six times a year. The service had a programme of 12 local audits planned for the year. For example, auditing mandatory involvement of consultant obstetricians on the hospital birth centre. The maternity service had a consultant obstetrician who was the maternity audit lead for the directorate. However, the maternity audit plan was part of the trust wide audit programme and did not include basic audits for maternity.

Management of risk, issues and performance

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

A risk register was used to identify and manage risks to the service. This included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings. A copy of the clinical dashboard was displayed in the meeting room on the hospital birth centre to share information with staff.

Mandatory training was concerned with minimising risk, promoting quality and ensuring the trust met external frameworks; for example, the Maternity Incentive Scheme, Ockenden (2020, 2022) Immediate and Essential Safety Actions and professional registration for midwives to ensure they complied with statutory requirements.

The trust monitored the number of incidents and serious incidents that staff reported monthly. Their target was to expect staff to report over 160 incidents monthly. The average number of monthly reported incidents was 160 in the 12 months prior to our visit. The average number of serious incidents was one per month during the same period.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation when things went wrong. Staff explained what had happened and apologised. They assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard.

Maternity

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs.

The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Managers told us they collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women's care. Managers also used this information inform decisions around service delivery such as continuity of care teams and community caseloads.

Engagement

Leaders and staff actively and openly 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.

There were systems in place to engage with staff. The senior leadership team told us the wellbeing of all staff was prioritised by senior leaders. There were staff boards in all the clinical areas which included staff name(s) and role(s).

The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP). The service had a well-established relationship with their MVP. The MVP was very proactive in co-designing maternity services to ensure women's views were represented. They also ran training for all staff on equality and diversity and the woman's voice. They had regular contact with the service and open access to the chief midwife and senior team. They attended formal meetings with representatives from maternity services, and local women.

The MVP worked with maternity services to bridge any gaps with women that could be harder to reach. They used social media platforms to connect with women, raise awareness, and act as their advocate. For example, they helped to co-produce a leaflet for women to raise awareness about the importance of vitamin D supplementation in pregnancy.

The trust valued their partnership working with the MVP and monitored their engagement. Their target was to meet at least every three months. This was monitored and reported through their maternity dashboard. It was recorded as a 'red flag' if they did not meet their target.

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The service worked with external organisations and monitored the number of requests for action from us, NHS Resolution and Healthcare Safety Investigation Branch. Any requests would be reported as a 'red flag' and monitored through their maternity dashboard.

There were staff and student information boards in all clinical areas. They included details of how to contact the maternity safety champions, the Freedom to Speak up Guardian, where staff could get support and a box where staff could make anonymous suggestions for improvement. The student information board included the standards expected of them.

There were information boards on corridor walls in all clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint and give feedback. Boards also included photographs of staff with their name and role

All staff wore yellow name badges. New starters were highlighted with badges that included the text 'I'm new here,' to raise awareness and help staff to support new colleagues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The maternity service provided specialist care as the South East London hub for a successful maternal medicine service. This provided clinical expertise to women and babies from South East London, Kent and Sussex.

The maternity service also provided a single site specialist service for women and babies who required specialist cardiac care. The service was co-located with the Evelina London level 3 Neonatal Intensive Care Service and the Evelina London Paediatric Intensive Care service. This included close liaison within the Evelina London Clinical Care Group with the Royal Brompton Hospital, who jointly provided care.

The trust developed maternity training pathways during the COVID-19 pandemic. They moved to virtual training and developed innovative techniques to engage staff.

The matron for the postnatal ward was setting up a working group to establish a postnatal contraception pathway. The aim of the project was to give support and advise on contraception prior to mothers' discharge. The group included third- and fourth-year medical students who had an interest in the project.

The Lambeth Early Action Partnership (LEAP), was formed in 2013 in response to the National Lottery Community Fund's invitation. This was to apply for funding to develop a ten-year programme of interventions designed to demonstrate the critical importance of evidence based early interventions in early childhood. The partnership came together to develop the bid and create a portfolio and was awarded £36M over ten years to deliver a range of interventions in the four LEAP wards of Stockwell, Vassall, Coldharbour and Tulse Hill. The Partnership comprised National Children's Bureau, Lambeth Council, Lambeth CCG, Public Health, Guys and St Thomas's Hospital, Kings College Hospital, South London and Maudsley, Evelina London, Kings Health Partners, local voluntary and community sector and parents.

Maternity

The partnership built on the effective working relationships that had its roots in the development of Lambeth's Sure Start and Children's Centre programme. The National Children's Bureau was the accountable body for the funding and acts as a facilitator to the partnership.

Outstanding practice

We found the following outstanding practice:

- The Butterfly bereavement suite which was co-deigned with parents who had experienced trauma and baby loss. They had worked with charities to fund additional resources and free counselling support for women and families who had experienced loss.
- The design of staff training which was responsive to staff needs and used innovative techniques. Human factors were weaved into all training to maintain their safety culture.
- Management of incidents. Staff understood the process because it was embedded into practice. There were options for psychological support. This included support from a clinical psychologist employed specifically for maternity services. The management of incidents was focused on learning and improvement, and staff wellbeing and psychological safety were protected throughout.

Areas for improvement

MUSTS

Action the maternity service must take to comply with their legal obligations:

- The service must ensure they have a clear process to ensure women are triaged and reviewed according to their risk and consider the suitability of reviewing women attending for planned appointments, unplanned appointments and labour assessments in the same area. (Regulation 12 (a)(b)(d)).
- The service must ensure they maintain safe staffing numbers in the triage area, to include dedicated staff to manage the triage telephone line (Regulation 18 (1)).
- The service must ensure staff trigger staffing concerns promptly to ensure they are re-deployed to the area most in need, to keep women and babies safe. (Regulation 18(1)).
- The trust must ensure records are held securely including computer access (Regulation 17(c)).

SHOULDS

Action the maternity service SHOULD take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services;

- The service should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target.
- The service should ensure all staff have an annual appraisal to support their learning and development.
- The service should ensure emergencies trollies and drugs contained with them are tamper proof.

Maternity

- The service should consider the environment to ensure women and their families can always be treated with respect and dignity.
- The service should review their infection prevention and control risk assessment for testing urine samples on a clinical trolley, in their midwifery assessment unit.

Our inspection team

We gave the service 48 hours' notice before we visited. We carried out a focused inspection. This does not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe and well-led. We visited the triage and maternity assessment area, the hospital birth centre, the high dependency unit, obstetric theatres, the home-from home birth centre, the antenatal ward and the postnatal ward. We spoke with 12 mothers/partners. We spoke with 61 members of staff, including service leads, midwives (bands 5-8), obstetric staff (junior-consultant), consultant anaesthetist, obstetric theatre staff, maternity care support workers, student midwives and the chair for the maternity voice partnership.

We observed the morning handovers on the antenatal ward, postnatal ward, hospital birth centre and home-from-home birth centre. We joined the multidisciplinary handover on the hospital birth centre, the morning safety huddle on the postnatal ward and the elective caesarean section pre-list briefing.

We reviewed performance information about this service before we visited. We reviewed five sets of maternity records and four prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, incidents and audit results

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing