Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Queen Elizabeth Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Queen Elizabeth Hospital.

We inspected the maternity service at Queen Elizabeth 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.

Queen Elizabeth Hospital provides maternity care and treatment to women, birthing people and babies from Woolwich and surrounding areas, as well as providing support to University Hospital Lewisham and working with other trusts from the Local Maternity and Neonatal System (LMNS). The LMNS covers Southeast London. Staff at the hospital delivered 4,181 babies between July 2022 and June 2023.

Maternity services at Queen Elizabeth Hospital includes an obstetric consultant-led delivery suite, maternity assessment unit (triage) and wards for antenatal and postnatal care. A midwife-led birth centre provides intrapartum care for women and birthing people who meet the criteria and are assessed to have lower risk pregnancies.

We last carried out a comprehensive inspection of the maternity service in September 2018.

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.

We did not review the rating of the location, therefore our rating of this hospital stayed the same Queen Elizabeth Hospital is rated requires improvement.

We also inspected one other maternity service run by Lewisham and Greenwich NHS Trust. Our reports are here:

University Hospital Lewisham - **https://www.cqc.org.uk/location/RJ224**

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited maternity assessment (triage and the day assessment unit), labour ward, the midwife-led birthing centre, the antenatal and postnatal wards.

We spoke with 3 women and birthing people and 3 birthing partners and or relatives. We also spoke with 19 midwives, 2 support workers, 4 doctors, 2 student midwives and 3 other staff. We received no responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 6 patient care records, 6 Observation and escalation charts and 6 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Maternity

Good →←

Our rating of this service stayed the same. We rated it as good because:

- Since our last inspection there has been an improvement to the time taken to investigate and respond to complaints.
- Staff worked well together for the benefit of women and birthing people. They understood how to protect women and birthing people from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Although the service had high vacancy rates, there were recruitment plans and a strategy in place to ensure staffing levels matched the planned numbers to ensure the safety of women, birthing people and babies. Staff received maternity specific mandatory training. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Leaders understood how health inequalities affected treatment and outcomes for women and birthing people that accessed the service and were proactive in developing innovations and quality improvement to improve equity and equality.

However:

- Staff did not always complete the hourly fresh eyes assessment to maintain the safety of women, birthing people and babies.
- Records of emergency equipment checks were not always maintained as required.
- The service did not always store medicines well nor remove out of date medicines as appropriate.

Is the service safe?

Good →←

Our rating of safe stayed the same. We rated it as good.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff were up to date with the trust mandatory training, which was an improvement from the last inspection. Training records showed that 93% of staff had completed their trust mandatory training such as health and safety, and fire safety.

Maternity

Maternity staff were also required to complete additional mandatory maternity specific trainings. Records showed that 88% of midwifery staff had completed the required maternity specific mandatory training courses against a trust target of 90%. Eighty per cent of maternity support workers (MSW) had most mandatory training, except for resuscitation, which was at 72%. Medical staff had an overall maternity specific mandatory training compliance of 85%. Eighty per cent of medical staff had completed resuscitation training, and 86% of junior and middle grade doctors had completed fetal wellbeing training.

Senior managers told us the reason for the low compliance with staff training was due to the cancellations of some of the study days due to recent industrial actions, staff sickness, redeployment of staff and the rotation of new large group of junior doctors into the service. There was a specific focus on improving training compliance for staff and senior managers had scheduled extra study days for staff in the coming months, particularly for staff with lowest training compliance. The trust training trajectory data showed that multidisciplinary team (MDT) staff would be up to date with their maternity specific training by 1 December 2023 in line with the trust target. Following this inspection, the service advised medical compliance with this training was at 80% at the beginning of November 2023, thereby in line with the trajectory for meeting the target.

The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Seventy-two per cent of midwifery staff, 80% of consultants and 59% of junior and middle grade doctors had completed CTG training. Senior managers told us the overall number of staff who had received this training was over 90% but figures had been lowered due to staff who had not yet achieved a pass for the competency assessment.

Not all staff had completed appropriate basic, advanced life support and neonatal advanced life support training. The trust target was 90%; medical staff compliance was 41% and nursing and midwifery staff compliance was 80%. This meant some staff did not all have training to provide lifesaving treatment to women and birthing people and babies in their care.

The service made sure staff received multi-professional simulated obstetric emergency training. Multi-professional training ensures all grades of staff practice dealing with and managing emergency situations, such as post-partum haemorrhage, together. Eighty-nine per cent of midwives and 90% of medical staff had received this training.

Post inspection, the trust provided us with the maternity cross-site data, which showed improvement in the completion of the resuscitation training and fetal monitoring training. From 3 November 2022 to 3 November 2023, compliance was 92% for MDT staff on both training modules. The consultants and midwives had met the trust target of 90% in the completion of the PROMPT, resuscitation, and fetal monitoring training modules. The junior medical doctors achieved an overall 92% compliance in the 3 training modules.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

The service had a team of specialist midwives to support staff to complete required training. This included 2 practice development midwives, a lead maternity support worker and administration support, 4 preceptorship support midwives, a clinical placement facilitator, and 2 fetal wellbeing midwives. They were overseen by a consultant midwife who had the lead for education in maternity across the trust.

Safeguarding

Maternity

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had maternity specific safeguarding training on how to recognise and report abuse.

Not all staff had received the maternity safeguarding training specific for their role on how to recognise and report abuse. Training records showed that not all staff had completed both maternity specific Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

The trust target for safeguarding training was 90%. Training data showed the overall compliance for maternity staff was 92.4% for the trust wide Level 1 to 3 safeguarding adults, children, and young people trainings. However, the level 3 maternity specific safeguarding training showed the medical staff compliance with safeguarding training targets varied between consultants and junior medical staff, and between adults and children's safeguarding. Consultant adult level 3 maternity specific training was 75% and the level 3 maternity specific children's and young people training was 95%. The junior doctor's adult training compliance was 31% and children was 34% for the maternity specific safeguarding training. This only met the trust target in one area for one group of staff. Nursing and midwifery staff compliance with training targets was 83%, which was slightly below the trust target of 90%. Following this inspection, the trust advised during the factual accuracy process that there had been improvement in the MDT staff compliance with this training. The maternity cross-site training data from November 2022 to November 2023 showed that 95% of Midwives, 90% of consultants and 85.3% of junior doctors had completed the level 3 safeguarding children training, thereby in line with the trajectory for meeting the target.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who visited each day and who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff had access to a regular group or one to one safeguarding and restorative supervisions, which was facilitated by the psychologists, specialist safeguarding midwives and professional midwifery advocates. Although, the specialist safeguarding midwives received weekly supervision from their named safeguarding midwife, they did not receive safeguarding and restorative supervision support, unlike the perinatal mental health and bereavement midwives. They believed having access to the safeguarding and restorative supervisions would help them to handle the highly complex safeguarding cases they had in recent years and prevent burnout. Post inspection, the trust told us the maternity team received quarterly restorative supervision from the practice development midwives.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had a baby abduction policy and staff described how it had recently been updated. We saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before this inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. We saw areas such as corridors and patient rooms, were visibly clean and free of dust, including in folds in chairs. Curtains and blinds were disposable and had been changed regularly.

Most cleaning records were up-to-date and demonstrated most areas were cleaned regularly. Temperature checks of the milk fridge had been completed, although we saw up to 5 omissions a month in the daily records. On some days the maximum temperature recorded was higher than the recommended temperature for safe storage, leading to a risk of deterioration of stored breast milk. Cleaning staff told us they recorded when they had cleaned each area, which provided information to other cleaning staff and assurance that areas that had not been cleaned were identified.

The service generally performed well for cleanliness. Leaders completed regular infection prevention and control and hand hygiene audits. Cleaning scores in May and June 2023 showed staff consistently performed well for cleanliness. Where there were exceptions, the trust implemented a cleaning action plan to address identified concerns.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff made sure their clothing was bare below the elbows, all areas stocked PPE at various intervals along walls as well as hand sanitiser.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Emergency equipment checks were not always completed. Staff were trained to use them. Staff managed clinical waste well.

Women and birthing people could reach call bells if they needed support and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. There was a monitored buzzer entry system to the maternity units and reception areas. These were staffed 15 hours a day, 7 days a week and visitors had to sign in. Out of these hours, staff on the wards and units had to admit visitors through the buzzer entry system. The service had dedicated maternity theatres and transitional care beds for women, birthing people and babies requiring a higher level of monitoring after delivery.

Staff carried out daily safety checks of specialist equipment. Records showed the resuscitation equipment outside maternity theatres was checked, although this was not always daily. We found there were a few gaps in checklists for adult resuscitation equipment of between 1 and 6 a month. However, there were more gaps in checklists for resuscitaires for babies, which averaged 6 a month, although one month had 11 missing checks. Checking all emergency equipment each day was a trust requirement.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

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

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. The service had a system to monitor equipment safety checks, which were last completed in June 2023. All equipment seen during our inspection visit had been checked within the last 12 months.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

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

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. The MEOWS chart is used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any woman or birthing person whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women and birthing people (MBRRACE 2016). We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed an audit of records to check they were fully completed and escalated appropriately. The July 2023 MEOWS audit result showed staff achieved 94% compliance.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage, although this was being reviewed at the time of our inspection. This had not been fully implemented due to challenges with the triage environment and staffing. Midwifery staff told us they were able to assess women and birthing people within the required 15 minutes.

The audit to review maternity triage waiting times between April to June 2023 showed midwives reviewed just over three-quarters (77%) of women and birthing people within 15 minutes of arrival. However, it also showed 11 women or birthing people who needed to be seen within 15 minutes of arrival were not seen in this timeframe. We did not receive information from the service to show whether women and birthing people were seen by medical staff within required timeframes. During our inspection visit staff told us timeframes for women and birthing people being seen by doctors was not monitored. They also told us women and birthing people could wait up to an hour to be seen as 2 obstetric registrars also covered labour ward and there was no dedicated doctor for triage.

The service recently introduced a dedicated telephone triage line available between 8am and 8pm, 7 days a week, with a dedicated staff member specifically for this role. Between 8pm and 8am, calls were transferred to delivery suite for a labour ward midwife to respond to.

Maternity

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks, such as the risk of developing blood clots, the risk of carbon monoxide poisoning or a reduction in the fetal growth. Assessments had been completed at each antenatal visit and staff recorded the outcome of assessments in patient notes.

Staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. It is best practice to have a 'fresh eyes' or buddy approach for regular review of CTGs during labour. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). We looked at the CTG and fresh eyes audits for 13 March 2023 to 02 July 2023 and found fresh eyes was completed in 66.5% cases and full CTG review hourly completed by case midwife in 66% of cases. Since our inspection the service has reassessed how they audit fresh eyes checks and identified an improvement to 73%. The service also told us they had one of the lowest hypoxic-ischaemic encephalopathy (HIE) rates in London, which they had maintained for several years. HIE is a type of brain damage, caused by a lack of oxygen to the brain before or shortly after birth, which can potentially be reduced by the completion of CTG fresh eyes checks and action if these are found to be unfavourable. These statistics were an improvement on audit findings of June to November 2022. Action plans were in place to improve compliance and results were shared with staff via newsletter and during handover. From May to June 2023, staff achieved 93% compliance in the World Health Organisation (WHO) surgical checklist audit.

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

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman or birthing person's intrapartum care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used the SBAR (Situation, Background, Assessment and Recommendation) tool to handover patients to others. The communication tool prompts staff to record key information and recommendations about patients. An audit of SBAR records over the last 12 months showed a 75% compliance rate, although this was 100% in the last month.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had a safety huddle each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. At birth, staff completed APGAR scores at 1, 5 and sometimes 10 minutes after birth. APGAR is a quick test performed on a baby to determine how well they are doing after being born. Staff also completed a Neonatal Early Warning Score (NEWS) to effectively monitor neonatal observations. The tool used a RAG rated system to alert staff to those babies who may require additional or transitional care.

The service provided transitional care for babies who required additional care.

Maternity

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Staff completed Newborn and Infant Physical Examination (NIPE) assessments of newborn babies before they could be discharged.

The service ran regular specialised clinics to support women identified with risks to ensure patient safety and improved outcomes. This included high risk multidisciplinary obstetric diabetic clinic, fetal medicine clinics, preterm clinics, postnatal review clinics and vaginal birth after caesarean clinic.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. We observed good access and flow in the service during inspection. The postnatal ward, while extremely busy during our visit, had designated discharge midwives in addition to the staff establishment to further strengthen the access and flow on the ward.

Midwifery Staffing

The service had high vacancy rates and had implemented several initiatives to ensure safe staffing levels and the safety of women and birthing people in the service. However, staffing levels did not always match the planned numbers.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings'. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. From February to July 2023 there were 49 red flag incidents.

Although, the number of midwives and healthcare assistants did not always match the planned numbers, this had improved in recent months. Senior staff discussed staffing levels across the trust maternity services each day, using a national framework. The Operational Pressures Escalation Levels (OPEL) framework has 4 levels (1-4) to determine how well a service can manage on staffing levels available and whether escalation is required. On the day of inspection, the maternity service safety huddle showed the service was at ‘OPEL 1’, indicating there were enough staff for the acuity (number of women, birthing people and babies) at the time and the service was able to meet the anticipated demand. However, for the period of February to July 2023, the unfilled shift rate for the maternity service averaged 21%, and this had not improved over time. This meant that although staffing levels had improved, the service’s ability to fill gaps in staffing had not improved.

The service introduced an ‘any hours’ programme earlier this year, which allowed staff total flexible working hours and patterns and they were able to choose when, where and the number of hours they wanted to work. The any hour's programme had gained national interest and staff and senior managers told us this had significantly improved the shift fill rates.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. Trust data showed 28.45 (21%) WTE vacancy rate for midwifery staff and mostly related to bands 5 and 6. The hospital had recently recruited midwives, including international midwives and newly qualified midwives, who were due to start in post before the end of the year. This would reduce the overall midwifery vacancy rate to 17.23WTE (13%) by December 2023. Senior managers were aware this would mean the high vacancy rate would be applicable throughout the service’s busiest period during September and October 2023.

Maternity

The service had higher sickness rates. The sickness rate for midwifery staff was 5.3%, which was higher than the trust target of 4%. The service had reducing turnover rates, although the rate for June 2023 was 12.7% for midwifery staff, which was still higher than the trust target of 10%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in May 2021. This review recommended 220.99 whole-time equivalent (WTE) midwives and maternity support workers band 3 to 8 compared to the funded staffing of 196.09 WTE, a shortfall of 24.90 WTE staff.

The service had a recruitment and retention strategy to recruit and retain staff as well as ensure unfilled shifts were covered. This included recruitment of preceptor midwives, international trained staff, a rolling advert for band 6 midwives and return to practice midwives. The trust had implemented several innovative schemes to retain existing staff and encourage those that had left or retired to return to work in the service. This included the 'midwifery apprenticeship' programme, which enabled career progression from band 2 to 6, conversion from bank to permanent staff and the 'any speciality' programme. This encouraged experienced midwives wishing to spend 2 days a month in a speciality of their choice to do so, to help improve their competency and skills needed to help their career progression.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. During inspection, we noted there was also a supernumerary shift co-ordinator covering the labour ward and triage. From February to July 2023, the service reported an average 99% compliance in the shift coordinator supernumerary status. On the one occasion in July 2023 when the supernumerary status could not be maintained, an additional staff member from the community setting was brought in to work in labour ward, so the supernumerary status could be reinstated.

Managers had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas to work in areas familiar to them.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Information from the service showed 88% of midwifery staff had received an appraisal in the previous 12 months, against a trust target of 90%. A practice development team supported midwives.

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 birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Maternity

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service always had a consultant on call during evenings and weekends. The consultants including the anaesthetists were available on site 8am to 8.30pm. There was off site on-call consultants cover from 8pm to 8.30am and registrars were available on site out of hours. There was adequate medical cover across the maternity unit including triage, day assessment unit and maternity wards.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The service had some vacancy, but low turnover and sickness rates for medical staff. Trust data showed there were no vacancies for obstetric consultants at the service but 3.4 whole time equivalent vacancies for junior medical staff. The sickness rate was 2% as at June 2023, which was better than the trust target of 4%. The turnover rate was 5%, which was better than the trust target of 10%.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

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

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records; electronic records were on a secure patient record system used by all staff involved in the woman or birthing person's care. We reviewed 6 paper and electronic records and found records were clear and complete. However, information provided about completion of 'fresh eyes' reviews of CTG readings showed these were not completed or recorded as often as required.

The trust was launching a maternity and postnatal clinical quality improvement (QI) project in September 2023, which aimed to fully digitalise the trust maternity records and remove reliance on current paper records. This was in line with the trust October 2022 maternity digital strategy.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. This was because the electronic records system linked to other hospitals using the same system.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. Staff told us they had enough mobile computers, which were used to document patient records by the bedside.

Medicines

Not all medicines were safe to use. Systems to ensure safe storage of medicines were not always completed by staff. However, the service used systems and processes to safely prescribe, administer and record medicines.

Maternity

Staff did not always store all medicines safely. Most medicines were in date, although we found 10 expired injections of anticoagulant in 2 different doses, stored together with unexpired injections in the same packaging, in one area of the service. This put women and birthing people at risk of receiving medicine that was not safe to use or may have been an incorrect dose. We spoke with staff who took immediate action to remove the expired medicine.

Staff monitored medicine room and fridge temperatures. However, there were up to 13 gaps a month in recording checklists in all areas of the service, where these had not been recorded daily. Some of these were explained by closure of an area, such as the birth centre, or failure of a fridge, but there were many more gaps than explanations. The head of midwifery advised a joint action plan had been developed with pharmacists to improve these areas in medicines management. An assessment had been undertaken and the risk had been added to the service risk register for closer monitoring. The service had also explored different solutions regarding environmental changes and were monitoring fridge temperature changes using a digital app.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Staff checked controlled drug stocks daily.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed prescription charts and found staff had correctly completed them. The maternity service had a dedicated ward pharmacist 7 days a week during specific hours and an on-call service out of hours. This supported medicine optimisation and provided additional resources for the discharge processes.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 6 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

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 and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 6 incidents reported in the 3 months before inspection and found them to be reported correctly.

Maternity

The service reported one 'never' event between 1 December 2022 and 21 June 2023, which was in relation to a retained swab. In response to this incident the service investigated, identified possible causes and developed a quality improvement project to implement actions to reduce the risk of reoccurrence. Although the service had only one incident of a retained swab, senior managers recognised there had been a larger number of similar incidents at other trusts close by. A group was set up to look at how these trusts could work together to eradicate the issue; preliminary findings identified possible causes and actions that could be taken to address the risk.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Moderate and serious incidents were reported to the board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly. Data from the maternity service showed that from January 2023 to April 2023 there had been 5 serious incidents declared. Four incidents had been reported to the Health and Safety Investigation Branch (HSIB) for investigation.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. The also took part in a shared learning meeting with other trusts in the LMNS to look at how each trust had responded and how they may be able to improve.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed serious incidents and shared learning at the service and divisional obstetric clinical governance meetings and take 5 meetings. Themes from serious and adverse incidents were used to update skills and drills and staff trainings.

The service held a weekly 'education bus' and quiz sessions in the maternity areas and the governance teams focused on different themes each month. For example, the team were focused on managing fluid balance in August 2023. There was evidence that changes had been made following incidents investigations.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good ➔➔

Maternity

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 birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them, which were shared with staff. There was a clearly defined management and leadership structure. The hospital maternity leadership team consisted of a cross site divisional director of midwifery, associate director of midwifery, a divisional medical director, a divisional director of operations manager and a hospital head of midwifery. They were supported daily by consultant midwives, lead clinicians, matrons, governance leads and specialist midwives.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The 2022 NHS staff survey also indicated staff responses were at similar levels to or slightly above the national average for feeling they were valued, listened to, and supported by managers. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. The director of midwifery held regular walkarounds and meetings which was a safe space for staff to receive updates as well as discuss any concerns with her. The clinical director met with the obstetric clinical leads weekly and had regular consultant meetings and introductory meetings with the new consultants.

Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were, and some their offices were located within the maternity unit.

Maternity safety champions and non-executive directors supported the service. The director of midwifery met with the Board maternity safety champion regularly. Both the maternity Board safety champion and the director of midwifery were aware of issues relating to the quality and safety of the service and were advocates for the service at Board level. We reviewed information of the safety champion walk abouts for June 2022. These showed a clear structure which covered relevant safety areas. Information from these walkabouts was reported back to staff in the maternity safety dashboard.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

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.

Maternity

The service had its own vision and strategy for what it wanted to achieve and how to do this, developed with all relevant stakeholders and in consultation with staff at all levels. Staff could explain the vision and what it meant for women, birthing people and babies.

The service's vision was to work together to provide high quality care for every patient every day and sculpt an exemplary user-led maternity service in London; one that was dynamic, culturally astute, and truly inclusive. They wanted to create an environment where every member of the team was valued, heard, and nurtured, recognising the unique contributions of their diverse workforce. Their strategy focused on 5 key priorities to achieve this: inclusive leadership, patient safety culture, growing workforce, multi-disciplinary training, and civility in the workplace. The patient safety culture would be achieved by implementing the patient safety incident response framework (PSIRF).

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at Lewisham and Greenwich NHS Trust. There were 5 recommendations made, including recording the twice daily ward rounds, embedding standard operating procedures, engaging with the Maternity Voices Partnership, and improving personalised care and support plans. Delivery of the service's Ockenden action plan was regularly mentioned as part of monitoring and governance processes, such as the safety champions meeting minutes.

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.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff we spoke with during our inspection visit felt respected, supported, and valued. They were positive about the hospital, its leadership team and felt able to speak to managers and leaders about difficult issues and when things went wrong. Staff told us they were happy at work and were supported by other staff. One staff member told us they, "Feel very valued in the team." Another staff member said they had, "Great experience, great support from all staff."

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. They spoke positively about their working relationships with other colleagues and told us there was no hierarchy amongst differently qualified staff. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Staff told us they had opportunities to progress and develop in their careers.

Leaders and staff understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes. In November 2020, the service developed a report following an online event that looked at getting maternity right for Black, Asian and Minority

Ethnic women, birthing people and their babies. This identified the top 5 priorities for the women and birthing people responding to the online event. Participants then identified groups of actions they thought would make the most difference and have a quick impact. The action with the most votes for being taken forward was training of staff, which they shared with the maternity team to help improve care.

Tackling health inequalities was a key priority for the trust and a core part of delivering their clinical strategy. In 2022/2023 the service had recruited a specialist smoke free pregnancy midwife to provide support across both hospital maternity services. As part of tackling health inequalities, the service had established 12 maternity learning disability champions and was delivering several staff awareness sessions to support women and birthing people with learning disabilities that accessed the service.

The South East Local (SEL) Maternity and Neonatal system (LMNS) had an equity and equality workstream and members met monthly to review specific aspects relating to health inequality. Their 3 main areas of focus were deprivation, language barriers and cultural awareness to identify where improvements could take place to improve equity and equality in the services offered to women and birthing people.

The hospital had ongoing work to improve equity and equality for women and birthing people which included close working with the local authority to develop family hubs in deprived areas for families to access service, advise and support and bringing care out to deprived communities. The trust provided support for women and birthing people with travel costs to attend appointment, partnering with foodbank to offer foodbank vouchers, partnership with local refugee and migrant networks and charities.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. Policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The trust worked closely with the population health and care analyst to develop a bespoke dashboard service to identify certain maternity cohorts such as smoking to drive improvement. Leaders monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. Since April 2023, the maternity service dashboard had captured the ethnicity data of women and birthing people who assessed the service and used this to analyse and identify any trends, outcomes and national performance data such as caesarean rates. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues faced by their population and provide better care for women and birthing people.

The infant feeding team held regular breastfeeding workshops in the maternity wards and in the community, including the hard-to-reach community. The team regularly received feedback from women and birthing people and monitored ethnicity data around infant feeding to help recognise and address cultural issues with breastfeeding and infant feeding to help improve outcomes.

In 2022, the trust maternity services launched the ‘Five X More’ wallets which was used to hold women and birthing people handheld antenatal notes, with the aim to empower them to advocate for themselves and promote positive health and wellbeing and tackle negative culture. The wallet had information for self-advocacy, wellbeing and advice for black and brown women and birthing people.

Maternity

The service celebrated staff and team success and supported good staff practice through the maternity newsletters, staff of the month, birthday of the month, thank you cards and staff awards. The service had a 11am wellbeing round, where senior staff supported staff to take their breaks to help promote wellbeing and prevent burn out.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. From May to July 2023, the service received 3 complaints, which were mainly related to staff attitude, treatment and care received. We noted a reduction in the number of complaints received from April 2023, which continued in July 2023.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. Information from the service showed in January 2023, 20 (47%) of complaints were overdue for completion. Since then, the service had acted and a significant statistical improvement was seen, which had been sustained over 6 months to July 2023. At the end of July 2023 there were only 2 complaints overdue for investigation. This was a significant improvement on this issue, which was raised at our last inspection.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a clearly defined governance structure that supported the flow of information from frontline staff to senior managers. The service worked with external agencies to ensure compliance with national reports and incentives, such as the NHS Resolution Maternity Incentive Scheme (MIS). Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The maternity service was on track with all measures outlined within the year-4 MIS and held regular meetings to discuss other areas, such as fetal and neonatal mortality reviews. Parental views and feedback were included for all cases and questions that parents had regarding care were included in the review to ensure they received timely and full feedback.

Leaders monitored key safety and performance metrics through a comprehensive series of governance meetings. Governance meetings were well attended by a multidisciplinary team and discussion included areas that covered performance data, audits and training, feedback, guidelines and research updates. The director of midwifery was responsible for leading on and reporting on this and other national outcomes to these agencies and to the trust board; they acted as an intermediary to keep staff and others updated.

Maternity services participated in both national and local audits, including the National Maternity and Perinatal Audit. This looked at statistical information about birth, such as the number of caesarean sections performed, whether an episiotomy (deliberate cut to avoid a tear during birth) was performed or the number of women and birthing people

who had given up smoking while pregnant. This showed the service's statistics between September 2022 and April 2023 for 3rd and 4th degree tears, at 4%, were slightly higher than average but within the median range, neither statistically significantly lower nor higher than national averages. Statistics for postpartum haemorrhage were higher than the national average and had increased steadily since July 2022 when they were last the same as the national average.

Learning from incidents and Healthcare Safety Investigation Branch (HSIB) recommendations were shared across the service. The Board was updated monthly about all maternity and neonatal serious incidents. The findings of incident reviews and investigations were discussed at the risk assurance meeting.

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. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed 13 policies and guidelines during inspection and note all were up to date and had a review date. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They generally identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders generally identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The service had a risk register and included risks such as staffing and environmental temperature. The risk register had control measures, actions to mitigate risks, progress made and the risk status. However, the risk register did not contain reference to the poor documentation of fresh eyes or the low training compliance (resulting from cancelled study days) rates as a concern on it's own or as part of any other risk.

The service participated in relevant national clinical audits. The service reported outcomes to the NHS Digital Maternity dashboard, the National Neonatal Audit Programme, the National Maternity and Perinatal Audit and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiry).

Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. These showed the service was better or at the national average for clinical audits, including 3rd and 4th degree tears and postpartum haemorrhage (PPH) of more than 1500ml. Managers monitored outcomes on the maternity scorecard, which provided statistical information monthly. When these statistical figures were outside national standards, these were discussed at risk meetings to ensure appropriate actions were taken to improve. Data supplied by the trust showed fetal monitoring (CTG) was recorded all the time, although some of the tasks associated with 'fresh eyes' monitoring was not. Appropriate escalation of concerning CTG recordings was always escalated. Managers used the results to improve women and birthing people's outcomes by sending staff information about what they were doing well and what they needed to improve on.

Managers and staff used the results to improve women and birthing people's outcomes. The service monitored how many women and birthing people smoked at the start of their pregnancies and at the birth of babies. A quality

improvement initiative was started in September 2020 when the rate of smoking at time of delivery was just over 7%, which was more than the national target of less than 6%. The initiative successfully reduced the rate of smoking at time of delivery to the national target. To sustain this improvement, the service introduced a 'Smoke-Free' midwifery role and recruited 2 midwives into the role in November 2022. The midwives' complete audits of clinical notes, provide training and advice to ward staff. Audits show that monitoring carbon monoxide (CO) levels at booking had increased since it was reintroduced in Autumn 2021 from an average of 64% to 83% in April 2023.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. However, the audit format for patient records was being reviewed and we were not provided with audit information following our inspection. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Managers developed a maternity safety dashboard each month that provided staff with an overview of incidents and risks identified during the previous month.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

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 service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Key information from the dashboard, score cards, audits and performance data were displayed across the service for staff, women, birthing people and public to access.

Data or notifications were consistently submitted to external organisations as required. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme, maternity dashboard, friends and family test (FFT) results and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records to access all the information they needed, including screening results and safeguarding information.

The information systems were integrated and secure**.** Electronic patient records systems were password protected to prevent unauthorised access. Paper records were stored in lockable cupboards.

Engagement

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

Maternity

There was no formal leadership of the Maternity Voices Partnership (MVP) which meant leaders struggles to engage with women and birthing people from the local population. Since our inspection, the service has recruited 2 joint chairpeople to the Greenwich MVP and is working to establish terms of reference and a working relationship.

Leaders had previously used information provided by the Lewisham MVP, who worked with leaders at the service's sister hospital, University Hospital Lewisham. Lewisham MVP had regular engagement with leaders to make a difference to services provided to women and birthing partners who accessed the service. They had been involved in co-production of leaflets and pathways such as the induction of labour leaflets, which were used in the service.

The Lewisham MVP were involved in the recruitment and interview process of senior maternity staff, such as senior managers.

The Lewisham MVP held regular focus groups and listening events to speak to staff and women about the maternity and MVP services and to obtain feedback. They held focus group for the LGBTQ+ community that accessed the sister maternity service to ensure their feedback could improve the experience for other LGBTQ+ women and birthing people. This gained an award for setting standards around how people were spoken to. The findings and recommendation from the focus groups and listening events had also been implemented in this service.

The service always made available interpreting services for women and birthing people and collected data on ethnicity, which was reviewed monthly in the maternity score card. Information on the maternity website could be translated to any language and the website had contrast and accessibility features to meet the needs of people with visual impairments or needs.

The service engaged women, birthing people and the public via their social media and website. The service engaged and received feedback from women and birthing people during ward rounds, birth reflection meetings and face to face resolutions following a complaint received.

The trust maternity services, Lewisham MVP and local Healthwatch had good connections with refugee and migrant support services to provide support for deprived and refugee women and birthing people who recently arrived the local areas. In 2021, the Greenwich borough housed 1000 migrants overnight into a local hotel from the Afghanistan relocation programme and several of those patients were pregnant. The following morning the trust maternity services conducted a specific antenatal clinic in the hotel to triage the vulnerable women and birthing people to determine how to best support and care for them. The trust developed specific triage forms and guidance to aid the assessment of the vulnerable women who had no maternity and obstetric care. This guidance had been shared with national and local maternity teams to drive learning and improvement.

Leaders understood the needs of the local population and knew their demographics. The trust data showed that women and birthing people that attended the service had complex social factors compared to the England average. The service actively worked to address inequalities and meet the individual needs of their population through a variety of ongoing work, such as bringing care to deprived communities and working closely with local authority to develop family hubs. The trust maternity service provided support to help women and birthing people with travel costs to attend appointments and partnered with local foodbanks.

They worked hard to engage the local community and patients in various ways such as listening events, a cultural humility survey, social media pages and through their website. There were numerous ways the public could engage with the service.

Maternity

The trust maternity service was part of the Southeast London LMNS Equity and Equality workstream that had been set up to improve the poor outcomes of women and birthing people who identified as Black, Asian, and ethnic minorities, those living in deprivation, and people with other protective characteristics. The group met monthly and assigned to review specific aspects relating to health inequalities- particularly around deprivation, language barriers and cultural awareness to drive improvement and equity in the service offered to women and birthing people.

Managers engaged with staff through various staff meetings, 'you said, we did' posters, forums, listening events and newsletters.

The service engaged with key organisations including other NHS trusts and local authorities and charities to improve on patient outcomes.

Learning, continuous improvement and innovation

The leadership drove continuous improvement and staff were accountable for delivering change. 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.

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. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Safe innovation was celebrated. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. We saw several examples of initiatives, innovations and quality improvement carried out in the service. This includes participation in a national study of post-partum haemorrhage (PPH) obstetric bleeding study. The service also participated in the cerclage (a treatment for a weakened cervix to sew it closed) after full dilatation caesarean section research, which focused on evaluating subsequent pregnancy risk of preterm birth in women with a prior caesarean section in established labour.

Quality improvement (QI) was routinely discussed at both quality improvement meetings and governance meetings. We saw that quality improvement was always an item on the agenda and staff were engaged in conversation about their ideas and innovations. Examples of QI projects that were completed or in progress included smoke free births, band 4 support worker management role, delayed cord clamping and bladder and pelvic health. The trust was also part of the on-going LMNS regional retained swab group. We saw that the service regularly presented completed QI project posters, such as the triage waiting time, and bladder and pelvic health at the trust's showcase events.

The service had set up joint midwifery and physiotherapy clinics for women and birthing people with perinatal pelvic floor issues. Data showed that 97.6% attendees of the clinics felt more confident in reducing pelvic health risks and 94.1% had more motivation to do pelvic floor exercises. Also, 91.8% had more confidence in pelvic floor exercises and the trust maternity service staff. As part of the project the team established telephone clinics and a safe and responsive 'trial without catheter' service at home, which resulted in a 90% success rate. The team were the winner of the May 2023 Royal College of Midwifery award. The trust maternity team was also part of the South East London Perinatal Pelvic Health Team which received the RCM 2023 'Partnership and Team Working' award.

Maternity

The joint perinatal pelvic floor clinic had helped reduce the use of containment products in the community which resulted in a saving of £100,000 in the 2022/2023 budget. The team were a finalist in the 2023 Advancing Health Care awards.

The Lewisham MVP in collaboration with the trust developed the cultural humility initiative which was funded by the southeast London CCG to ensure expectant and new parents received high quality care during and after pregnancy regardless of their cultural backgrounds. A quality standard was developed to provide guidance for all staff in the trust providing care for people throughout their maternity journey and aimed to increase the involvement of BAME service users accessing the service. The standard was used to create awareness for staff on how people from different backgrounds experience maternity care, and how cultural differences might impact on this.

A trust maternity support worker was awarded the 'Race Matters unsung hero' award in May 2023 under the MSW or student category for her work in setting up an innovative support hub to help women and families through cost-of-living crisis. The staff had collected and delivered essential items such as safe bedding and warm clothing as well as offering physical and emotional support to women and birthing people while visiting them postnatally.

The trust maternity service was one of the four early adopter sites for the implementation of the Tommy's clinical decision tool app. The project aimed at embedding the tool into routine practice to assess risk of pre-term birth and placental dysfunction and to replace previously used checklists. The app was shared between professionals, women, and birthing people to ensure they received the right care at the right time to help save babies lives.

The service offered a 1-day expectant fathers programme on a Saturday to improve experience, enhance competence and confidence as a father. The course included theoretical and practical tips and skills, and expectant fathers also had opportunities to ask midwives any questions.

A member of the medical staff and the MVP developed a group for women and birthing people with gestational diabetes to share a recipe to help with managing their condition. The collaboration ensured the recipe reflected the diverse cultural needs and tradition of people who accessed the service including Afro-Caribbean and Eastern European.

The trust maternity service was running a pilot digital communication translation programme which aimed to reduce health inequalities by improving communication through better translation solution between health professionals and patients by use of an app or website.

Outstanding practice

We found the following outstanding practice:

- The joint midwifery and physiotherapy clinic team won the Royal College of Midwifery (RCM) 2023 award for the implementation of the joint perinatal pelvic floor clinic to support women and birthing people with pelvic issues.
- The pelvic floor quality improvement project was a finalist in the Advancing Healthcare Awards 2023 for reducing the use of containment product in the community.
- The recording and analysis of ethnicity data of women and birthing people in the maternity dashboard in relation to national outcome and targets to drive improvement was exemplary. The service recognised and understood their women and birthing people groups and the additional challenges the women and families who accessed the service faced. Particularly around health inequalities, deprivation, co-complexities, and co-morbidities.

Maternity

- Leaders were proactive and innovative in addressing staffing issues and developed several staffing initiatives such as 'any speciality' and 'any hours', which had gained national interest.
- The service provided antenatal clinics in a hotel within 24 hours of pregnant Afghanistan refugees arriving in the country and accommodated.
- The hospital had invested in the provision of a 7-day maternity pharmacy service cover to ensure the safety of women and birthing people and timely discharge from the service.
- The service developed 'champion' roles for 12 staff to improve staff awareness and support women and birthing people with a learning disability.

Areas for improvement

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

Action the trust SHOULD take to improve:

Queen Elizabeth Hospital

- The service should continue to address the vacancy rates in the service.
- The service should ensure staff complete daily checks of emergency equipment.
- The service should ensure appropriate action is taken in a timely manner when fridge temperatures are out of range.
- The service should ensure specialist staff have access to appropriate safeguarding supervision to carry out their duties.
- The service should ensure staff complete and document fresh eyes observations in line with national guidance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors, plus 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.