Lewisham and Greenwich NHS Trust

University Hospital Lewisham

Inspection report

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Ratings

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

Our findings

Overall summary of services at University Hospital Lewisham

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 University Hospital Lewisham.

We inspected the maternity service at University Hospital Lewisham 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.

University Hospital Lewisham is based in Lewisham, Southeast London and is part of the Lewisham and Greenwich NHS Trust and the Southeast Local Maternity and Neonatal System (LMNS). The hospital provides maternity services to women living across the boroughs of Lewisham, Greenwich, and Bexley.

The maternity service at University Hospital Lewisham included a range of antenatal, intrapartum, and postnatal care and comprises of a maternity day assessment unit, antenatal clinic, maternity wards, triage unit, delivery suite, maternity led unit, home birth service and a community midwifery service. Additional antenatal and postnatal services are provided at the sister site, Queen Elizabeth Hospital in Woolwich. From July 2022 to June 2023, there were 3,124 deliveries at the hospital.

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 an 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. University Hospital Lewisham overall rating is requires improvement.

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

Queen Elizabeth Hospital – **https://www.cqc.org.uk/location/RJ231**

How we carried out the inspection

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

We visited the maternity theatres, maternity assessment (Triage), labour ward, birth centre, day assessment unit, the antenatal and postnatal wards and antenatal clinics.

We spoke with 40 multidisciplinary staff, 2 women and birthing people and 2 birthing partners and or relatives.

Our findings

We reviewed 8 patient care records, 8 Observation and escalation charts and 8 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 the last inspection, there has been improvement to staff appraisal rate, fetal monitoring equipment, medicine fridge temperature checks and daily check of glucagon injection.
- Staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service managed infection risk 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Leaders at all levels demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Staff understood the service's vision, strategy, and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- There were high levels of staff satisfaction across all equality groups. 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 promoted equality and diversity in daily work and provided opportunities for career development.
- 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. 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.
- The leadership drove continuous improvement and staff were accountable for delivering change. All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However:

- 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 did not always complete the hourly fresh eyes assessment to maintain the safety of women, birthing people and babies.

Is the service safe?

Good 

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

Mandatory training

Maternity

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 wide mandatory training. Overall compliance for all staff groups in their trust mandatory training as at 31 July 2023 was 93.9%, which was an improvement from the last inspection. The junior doctors achieved 92% overall compliance for the trust mandatory training.

The trust data showed that not all staff were up-to-date with their maternity specific mandatory training particularly the junior doctors in line with the trust's own target. The trust cross-site maternity data showed that from 1 July 2022 to 31 July 2023, 90% of staff had completed the multi-professional simulated obstetric emergency training (PROMPT). In the same period, staff had achieved 87% compliance in the completion of the fetal monitoring training and 83% compliance in the completion of the resuscitation 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. Two training sessions, fetal monitoring and resuscitation, were cancelled in June 2023, to ensure staff were available to provide safe clinical care during the periods of strike action. 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 and the Clinical Negligence Scheme for Trusts (CNST) target.

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.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, perinatal mental health, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

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 education team and senior managers reviewed the staff training needs analysis to ensure it reflected the needs of the service and learning from complaints and incidents. The education team monitored training compliance and kept a record of the maternity services trust-wide data. The education team consisted of 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.

Staff also had access to support for external training to maintain their competences. For example, the bereavement midwife had attended a study day in July 2023 which focused around supporting bereaved Muslim families effectively.

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 training on how to recognise and report abuse and they knew how to apply it. Staff were up to date with the trust safeguarding training.

Staff were required to complete a maternity specific level 3 adult and children training as well as the trust wide safeguarding adult, children and young people level 1-3 trainings. Staff were up to date with the trust wide safeguarding level 1-3 trainings and had achieved an overall 94.3% compliance which was better than the trust target.

However, not all staff had received the maternity safeguarding level 3 adults and children training specific for their role on how to recognise and report abuse. Training records showed that as of 24 July 2023, the overall Level 3 safeguarding adults and children training compliance rate for midwifery staff was 81% and 89% for all medical staff for their role as set out in the trust's policy and in the intercollegiate guidelines. However, the compliance rate for junior doctors was low, which was 65%. 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. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples that 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 staff could turn to when they had concerns. They also supported staff with discharge planning meetings, drafting safeguarding reports and attending safeguarding meetings such as crisis management meetings and case conferences. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted in the 12 months before this inspection.

The service held regular safeguarding and mental health clinics to support women and birthing people with safeguarding and mental health concerns to minimise patient risk and improve outcomes.

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. This meant they did not have access to safeguarding and restorative supervision which could impact on their personal resilience and ability to continue to support complex safeguarding cases. Post inspection, the trust told us the maternity team received quarterly restorative supervision from the practice development midwives.

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.

There were systems to ensure the deep cleaning and decontamination of rooms following a discharge or transfer. Curtains and blinds were disposable and had been changed regularly.

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.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained, except triage where we found dust on a urinalysis machine and 2 bed legs. This was escalated to senior staff and was addressed immediately. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly except triage where we observed 52 gaps in the triage room daily cleaning checklist from May to July 2023.

The service generally performed well for cleanliness. Leaders completed regular cleaning, infection prevention and control and hand hygiene audits. From June to July 2023, the service achieved an overall 98.3% compliance in the cleaning audit.

Data showed hand hygiene audits were completed every month in all maternity areas. In the period of May to June 2023, the overall compliance in the hand hygiene audit was 93% and 100% for the infection prevention and control personal protective equipment (PPE) and isolation audit.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients, and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas.

Staff followed infection control principles including the use of PPE.

Environment and equipment

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

Call bells were accessible to women and birthing people 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, which reduced the risk of baby abduction. The maternity areas and storage areas were locked and secured, which was an improvement from the last inspection.

Maternity

The service had dedicated maternity theatres and transitional care beds for women, birthing people and babies requiring a higher level of monitoring after delivery. The theatres were accessible 24 hours a day for an emergency caesarean section.

Staff generally carried out daily safety checks of specialist equipment in the maternity areas. However, we observed 2 out of date emergency airways on the antenatal ward. The out-of-date items was escalated to staff, and they were removed and replaced immediately. Records showed resuscitation and other emergency equipment such as post-partum haemorrhage (PPH) trolley were checked daily.

The May 2023 environment and equipment audit showed an overall 97.3% compliance against a trust target of 90%.

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

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 carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas. A ligature risk assessment was last carried out January 2023.

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.

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.

We observed hat all equipment which required electrical safety testing and service maintenance were completed within the appropriate timeframes.

The service had a furnished bereavement room to care for bereaved mothers and their families. However, this had not been soundproofed as recommended in national guidance. This meant bereaved mothers could hear other babies crying on the ward. To mitigate this, the bereavement room was situated in a quieter area of the ward with easy access in and out of the room for the bereaved families to help prevent them seeing or hearing the cries of other babies.

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. Staff also used the clinical assessment tools to assess and identify deterioration in newborn babies. We reviewed 8 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a quarterly audit of records to check they were fully completed and escalated appropriately. From August 2022 to July 2023, staff achieved 95% compliance in the MEOWS audit.

From August 2022 to July 2023, staff achieved 85% compliance in the timing of induction.

Maternity

Staff completed risk assessments for women and birthing people on arrival, using a recognised modified tool, and reviewed this regularly, including after any incident. The service was working towards fully re-implementing an evidence-based, modified standardised risk assessment tool for maternity triage. This had not been fully implemented due to the triage environmental and staffing challenges. We were not told the time frame for the full implementation of the risk assessment tool. At the time of the inspection, the service was planning on expanding the triage environment by reconfiguring one of the labour ward rooms to use to triage women and birthing people. Staff told us there had been improvement in the triage process and staffing since their regional maternity assurance visits and they now had a dedicated support worker in triage on every shift which have improved the access and flow.

Triage was located on the labour ward and there were 3 maternity telephone helplines located there, which was manned by an administrative staff and a midwife. The service was planning on implementing a dedicated maternity triage telephone line following the successful implementation at the trust's sister hospital.

The maternity triage waiting times for review audit for April to June 2023 showed midwives reviewed 51% of women and birthing people within 30 minutes of arrival. The trust had a policy which showed the expected time women need to be prioritised and reviewed based on the clinical urgency. The April to June 2023 audit, showed an overall 49% compliance in the numbers of women reviewed by the midwives within the expected time in the different categories. Staff and senior managers told us the low compliance was related to documentation but mostly around the limitations of the previous audit collection tool used. A re-audit was carried out in August 2023, which showed an improvement in audit result, data collection and analysis. The result showed 74% of women and birthing people were reviewed by midwives within 15 minutes of arrival and 87% were seen within 30 minutes of arrival. The audit also showed that women experienced few delays before been reviewed by the doctors. The result showed 56% of women were reviewed by doctors within 15 minutes and while 75% were reviewed by doctors within an hour after their initial assessment by the midwife.

Staff told us and we observed during inspection that women and birthing people did not experience delay before being reviewed by midwives and doctors. Managers were assured women did not experience delay before being seen and assessed by midwives and doctors as this was monitored through their escalation routes, incidents and complaints. The triage was located in the labour ward, which helped in the timely assessment and escalation to doctors.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The March to July 2023 CTG audit showed clear interpretation, escalation and management plans following CTG in over 90% of cases, 100% women and birthing people had fresh eyes reviews completed; however, staff did 'fresh eyes' at each hourly assessment in 65% of cases. The low compliance in the hourly compliance relates to partial compliance in all standards audited such as gaps in documentation. Action plans were in place to improve compliance and results were shared with staff via newsletter and during handover. Since our inspection, as part of the factual accuracy process the service has reassessed how they audit fresh eyes check and identified improvement to 75%. The trust told us improvements were being made to improve the documentation of fresh eyes. The trust provided us with data which showed that the trust maternity services had one of the lowest hypoxic-ischemic encephalopathy (HIE) rates in London and had maintained this consistently 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. From May to June 2023, staff achieved 93% compliance in the World Health Organisation (WHO) surgical checklist audit.

Maternity

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

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 person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women, birthing people and babies safe including safeguarding, mental health, neonatal review, septic screen, feeding support, discharge plan. During the inspection we attended staff handovers, which was attended by multidisciplinary staff and found staff used the situation, background, assessment, recommendation (SBAR) tool to handover care and all the key information needed to keep women, birthing people and babies safe was shared.

The July 2023 SBAR audit showed 100% compliance against the trust target of 90%. Staff had regular safety huddles 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. We saw examples of staff discussing tongue tie referrals, transitional care plans, asylum seeker safeguarding plan during handovers and ward rounds.

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 help health professional determine how well the infant is doing after being born.

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

Newborn checks were mainly completed by the paediatrician and advanced neonatal practitioner. The service had also trained some midwives on the 'Newborn and Infant Physical Examination' (NIPE) programme which was carried out within 72 hours of birth. Staff told us there was always a trained NIPE midwife on each shift. Women were given a scheduled time for the newborn checks of their baby which helped improve access and flow in the service and ensure timely checks of newborns to minimise risk.

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.

The service held regular joint multidisciplinary clinics and meetings such as the monthly joint obstetric neurology clinics and a joint substance misuse clinic. The service also held a weekly MDT meeting, which was led by a consultant midwife for the team to discuss, review and plan care for women and birthing people with complex needs.

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 had completed several specific trainings on various topics such as sepsis, blood transfusion, fire safety, life support, neonatal resuscitation skills to ensure they were competent to manage and minimise safety risks to women, birthing people, and babies.

Maternity

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 had designated discharge midwives in addition to the staff establishment to further strengthen the access and flow on the wards on Mondays to Fridays.

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.

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 66 red flag incidents.

Although, the number of midwives and healthcare assistants did not always match the planned numbers this had improved in recent months. For the period of February to July 2023, the unfilled shift rate for the maternity service averaged 31%. We noted the unfilled shift rate was high in February 2023, which accounted for 41 % of shifts, however, there had been significant improvement in recent months. The unfilled shift rate had dropped down to 24% in July 2023.

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.

For the period of September 2022 to June 2023, 99.6% of women received one to one care during active labour against the trust target of 100%.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. Staffing was monitored by senior managers daily at various meetings, such as the cross-site safety huddle meetings. They completed a maternity safe staffing workforce review in line with national guidance in May 2021. This review recommended 179.93 whole-time equivalent (WTE) midwives and maternity support workers from Band 3 to 8 compared to the funded staffing of 169.94WTE, a shortfall of 9.9WTE staff.

The service had a recruitment and retention strategy and plan in place to recruit and retain staff as well as ensure unfilled shifts were covered. This included recruitment of preceptor midwives, internationally 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'. The any speciality programme 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.

Maternity

There were at least 2 supernumerary shift coordinators on duty around the clock who had oversight of the staffing, acuity, and capacity. During inspection, we noted there were 3 shift co-ordinators covering the labour ward and triage. From February to July 2023, the service reported an average 99% compliance in the shift coordinator supernumerary status.

The ward manager 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 and areas familiar to the staff member.

The service had low sickness rates. The sickness rate for midwifery staff was 3.1% against the trust target of 4%. The service had reducing turnover rates. The staff turnover rate as of 11 August 2023 was 11.6% for midwifery staff which was slightly higher than the trust target of 10%.

The service had reducing vacancy rates and high use of bank nurses to cover sifts. Trust data showed 19.4WTE (16%) vacancy rate for midwifery staff and mostly related to band 5 and 6 staff. The hospital had recently recruited some midwives including internationally trained midwives who were due to start in post before the end of the year, which would reduce the overall midwifery vacancy rate to 4.43WTE (3.92%) by December 2023.

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. The overall appraisal rate for the maternity service was 89% at the time of inspection. Staff we spoke with during inspection had completed or booked their annual appraisal. 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.

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 units including triage, day assessment units and maternity wards.

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

Maternity

The service had low vacancy rates, sickness rate and turnover rates. Trust data showed there was 1 vacancy for medical staff (obstetric consultant). The sickness rate was 2.1% as at June 2023, which was better than the trust target of 4%. The turnover rate was 6.3% 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.

The anaesthetic rota was compliant with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1 and the maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward for elective and emergency caesarean sections.

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 women and birthing people's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, records were not always up-to-date in the documentation of fresh eyes.

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. We reviewed 8 paper records and found records were clear and complete.

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.

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.

Staff in the maternity, paediatric and community division achieved an overall 94% compliance on the documentation audit from August 2022 to July 2023 against a trust target of 90%. However, the March to July 2023 CTG audit showed poor compliance in the documentation of fresh eyes.

Medicines

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

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 8 prescription charts and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The maternity units had dedicated ward pharmacist cover 7 days a week which is considered exemplary, as it can help improve patient safety and experience, medicine optimisation and discharge process. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them 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 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. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation such as resetting the fridge and escalating to the pharmacist. This was an improvement from the last inspection.

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

We found medical gas cylinders used in the maternity areas were stored appropriately in a locked room, in line with national guidance. Oxygen cylinders were full and within date.

Training data showed that 89% of staff were up to date with their medicines training against the trust target of 90%.

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. Staff reported a healthy incident reporting culture, and we observed incident trends and lessons learnt were displayed in the clinical governance staff notice boards in all areas during inspection.

The service had no 'never' events on any wards in the last 12 months.

Staff reported serious incidents (SIs) clearly and in line with trust policy. From 01 July 2022 to 30 June 2023, the trust reported 6 serious incidents in the maternity services. This related to still births, neonatal deaths, intrauterine deaths, babies born in poor condition and baby cooling. We reviewed 3 incidents reported in the 3 months before inspection and found them to be reported correctly. Managers debriefed and supported staff after any serious or adverse incident.

Maternity

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly and potentially those related to health inequalities. They involved women, birthing people, and their families in these investigations.

Staff understood the duty of candour. They were open and transparent and gave women, birthing people and families a full explanation if and when things went wrong. Managers shared duty of candour and draft reports with the families for comment. 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.

Managers shared learning with their staff about never events and serious incidents that happened elsewhere. The service had specialist midwives who was responsible for sharing learning from incidents with staff.

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 training.

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 explained and gave examples of additional training, process, pathway, and policy implemented following a serious incident. Following a baby abduction incident which occurred last year, the trust had implemented a new baby abduction policy and employed security staff for the maternity wards to maintain patient safety. The service had also introduced 2 hourly security rounds and a sign in register to ensure oversight of everyone entering and exiting the maternity wards.

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

Is the service well-led?

Outstanding ☆ ↑

Our rating of well-led improved. We rated it as outstanding.

Leadership

Leaders were compassionate and inclusive. Leaders at all levels demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. 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 a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. Leaders had an inspiring shared purpose, strive to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service. Leaders had a deep understanding of the issues, challenges and priorities in the service, and beyond. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

Maternity

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.

The senior leaders felt well supported by their managers, maternity safety champions and trust executives, such as the chief executive, to deliver their role effectively. They reported having regular appraisals from their managers as well as having regular meetings with the staff they managed.

Leaders were visible and approachable in the service for women, birthing people and staff. For example, the director of midwifery held regular walkarounds and 'Ask Shirley' 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.

The service was supported by the trust maternity safety champions and non-executive directors (NED). Staff told us the maternity safety champions and trust executives regularly carried out a walkaround of the maternity service, which was well advertised in advance. The service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent NED visits.

The service leaders told us they had good support and direct access to the trust board, and this worked very well. We saw from the minutes of board meetings that the trust board had oversight of the maternity service performance and received presentations regularly on the progress to national maternity safety recommendations.

The leaders 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. Strategies and plans were fully aligned with plans in the wider health economy, and demonstrated a commitment to system-wide collaboration and leadership. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy 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. Also, to create an environment where every member of the team was valued, heard, and nurtured, recognising the unique contributions of their diverse workforce. This would be achieved by their strategy, which focused on 5 key priorities: 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).

Maternity

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports, the trust 2021-2026 strategy, NHS Long term plan, NHS people plan, NHS Workforce plan and their maternity single-delivery plan on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

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

Leaders had an inspiring shared purpose and strived to motivate staff to succeed. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. There is a strong commitment and effective action towards ensuring that there is equality and inclusion across the service. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

There were high levels of staff satisfaction across all equality groups. Staff felt respected, supported, and valued**.** Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. For example, several staff spoke positively about the inpatient maternity ward managers and that they listened and escalated staff concerns immediately to senior managers.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture which placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Staff spoke positively about the safety culture, collaborative working, and supportive relationship between multidisciplinary team (MDT). There were opportunities to learn together, challenge each other positively and staff said there was no hierarchy among MDT staff. Several junior and senior staff had been working at the trust for years and staff told us there was equal opportunity to progress in their career. We saw examples of staff who had progressed to a leadership role over the years from junior staff, student midwives, and trainee doctor roles.

Leaders and MDT 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. Tackling health inequalities was a key priority for the trust and a core part of delivering their clinical strategy. 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. In 2022, the trust had recruited a specialist smoke free pregnancy midwife to provide support across both hospital maternity services. As part of the 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 Southeast 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 in equity and equality in the services offered to women and birthing people.

Maternity

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 services, advise, support and bring care out to deprived communities. The trust provided support for women and birthing people with travel costs to attend appointments, partnering with foodbanks to offer foodbank vouchers, a partnership with local charities.

Leaders monitored outcomes and investigated demographic data to identify when treatment and outcomes differed for different groups of people, such as those from ethnic minority groups or from deprived communities. 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 a regular breastfeeding workshop in the maternity wards and in the community, including harder-to-reach community areas. The team regularly received feedback from women and birthing people and monitored ethnicity data around infant feeding. This helped recognise and address any cultural issues faced with ethnic minority women and birthing people around breastfeeding and infant feeding to help improve outcomes.

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. This included diverse and inclusive workforce, career progression, monitoring of ethnicity data, tackling health inequalities and fair treatment and opportunity for staff, women and birthing people. All policies and guidance had an equality and diversity statement. All staff told us they worked in a fair and inclusive environment.

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 women and birthing people from ethnic minority groups.

The trust maternity services were working closely with SEL LMNS to address language barriers by developing generic videos and antenatal teaching slides to be translated into languages that reflected the languages spoken by the local community.

The hospital maternity service was the first service in UK to be awarded the Gold Pride in Practice Award. The pride in practice is a national quality assurance training programme that strengthened and developed a healthcare providers’ relationship with their LGBTQIA+ patients. The training was funded by the Lewisham ICS in response to service user feedback to equip staff with the skills and knowledge to provide LGBTQIA+ patients with a positive, affirming, and equitable maternity service.

There was a strong sense of pride of the service, hospital and community from our discussion with staff, Maternity Voices Partnership (MVP), women, birthing people, and families. We heard several comments from women and staff around how the community stood up when needed, to address issues and save the hospital from being de-commissioned.

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.

Maternity

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Staff at all levels are actively encouraged to raise concerns. 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 in a timely way, identified themes, 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 8 complaints, which were mainly related to staff attitude, treatment and care received. At the time of inspection, the service had zero complaints outstanding for the completion of investigation. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

The May 2023 trust freedom to speak up annual report, highlighted that a member of staff made observations of 'systemic racism' in the hospital maternity service, which was escalated to the maternity leadership team with recommendations given. Managers told us the feedback was taken seriously and recommendations had been looked at to support a programme of actions, which has helped to further improve the service. All staff we spoke to during inspection reported a positive culture in the service and have not experienced or witnessed racism, bullying or harassment in the service.

Governance

Leaders operated proactive and 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.

There was a clearly defined governance structure that detailed the governance oversight and accountability from the service level to the trust board level. The service had a strong governance structure which supported the flow of information from frontline staff to senior managers. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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.

Governance meeting agendas included discussion around all aspects of governance and oversight of the service such as performance data, audits and training, feedback, guidelines, and research update. Governance meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Outcomes of governance meetings and service dashboards were shared with staff through emails, take 5 meetings, newsletters, and posters.

Maternity

We reviewed the trust board minutes which showed that maternity items were regularly part of the meeting agenda, such as serious incidents, performance reports, national maternity reports recommendations, performance data, external investigation reports, Clinical Negligence Scheme for Trusts (CNST), workforce pressures and feedback. The trust board had been very supportive to address and improve staffing pressures which had been added to the trust corporate risk register. From the governance minutes reviewed, we noted that the maternity service had achieved full compliance against each of the 10 CNST standards. The service was also fully compliant with a national maternity immediate and essential recommendation actions.

Senior managers and staff told us the governance of the maternity services had been further improved and strengthened through the implementation of their maternity single delivery plan. This plan comprised all the national maternity recommendations and action plans and top risks or areas of improvement from external review, inspections, and performance data.

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.

The service participated in relevant national clinical audits such as the Perinatal Mortality Surveillance report, and the National Maternity & Perinatal Audit (MBRRACE). Outcomes for women and birthing people were positive, consistent, and met expectations, such as national and local standards. This included smoking at birth, breastfeeding initiation rate, post-partum haemorrhage and term admission. From September 2022 to June 2023, the average breastfeeding initiation rate was 91%, which was better that the 80% trust target. The service was not an outlier on any of the national audits and met all the standards in the General Medical Council (GMC) 2022 survey. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. 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.

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

Information Management

Maternity

The service demonstrated commitment at all levels to sharing data and information proactively to drive and support decision making as well as system-wide working and improvement. 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 which were password protected to access all the information they needed, this included screening results and safeguarding information.

During inspection we observed staff protect patient identifiable information in line with General Data Protection Regulations (GDPR).

The information systems were integrated and secure**.**

The 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 and/or needs.

Engagement

Leaders and staff collaborated and developed services with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches were used to gather feedback from service-users, including people in different equality groups, and there was a demonstrated commitment to acting on feedback.

We saw consistently high levels of constructive engagement with staff, including all equality groups. There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

Leaders worked with the local MVP to contribute to decisions about care in maternity services. Service leaders had built meaningful relationships with the local MVP and encouraged them to attend meetings on site, such as the labour ward forum and monthly women's experience committee meeting. The MVP were passionate about their role, had regular engagement with leaders to make a difference to services provided to women and birthing partners who accessed the service. The MVP had regular meetings with the trust and easy access to the senior leadership team to escalate any concerns promptly.

Maternity

The MVP held regular focus groups, listening events and 'mocktail drink rounds' across the service to speak to staff and women about the maternity and MVP services and to obtain feedback to drive improvement. We noted that they held focus groups for the LGBTQ+ community that accessed the service to improve their experience, which had gained an award for setting standards around how people were spoken to.

The MVP also engaged with charities and external organisations to address inequalities and improve the experience and outcomes of women, birthing people and families that accessed the service. This included work with a mental health charity to provide support, wellbeing and diversity matters groups for BAME women and a 'Being Dad' wellbeing group for men who cared for children under 2 years old. The MVP had also worked collaboratively with the children centres during the COVID pandemic in registering parents to the children's centres and creating awareness on vitamin D by giving out information leaflets.

The service and MVP also engaged women and the public using social media and their websites. The service engaged with 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 and hospital MVP had good connections with refugee and migrant support services to provide support for deprived and refugee women and birthing people who recently arrived in 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 women and birthing people 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 or obstetric care. This guidance had been shared with national and local maternity teams to drive learning and improvement. The service had also contributed to the Royal College of Midwifery 'caring for vulnerable migrants' guidelines.

In 2021, Lewisham borough was formally recognised as sanctuary for migrants and refugees and the service had worked closely with local migrant and refugee networks review their maternity oversea charging leaflet. The service also held workshops with women not eligible for free maternity care to listen to their experiences. This resulted in the implementation of the trust maternity compassionate policy, which voided bills for pregnancy losses and adverse outcomes, such as neonatal deaths, and stopped itemised antenatal billing that compared different modes of delivery.

Leaders understood the needs of the local population and knew their demographics. The trust data showed women and birthing people who attended the service had complex social factors compared to the England average. We noted the service actively worked to address inequalities and meet the individual needs of their population through various ongoing work, such as bringing care to deprived communities and working closely with local authorities 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 strove to engage the local community and service users 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 protected characteristics. The group met monthly and were 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.

In the 2022 CQC Maternity Survey, the trust performed somewhat better than expected on 1 standard, about the same on 40 standards and worse or somewhat worse than expected on 10 standards, when compared with most other trusts.

In the 2022 General Medical Council national training survey (GMC NTS), the hospital maternity service scored similar than average on all standards and better when compared to the sister site.

Feedback from women we spoke to during inspection was positive. Specific comments received include "care pathway phenomenal", "given loads of feeding support", "midwives check often and come quickly when called", "almost too much support and had to ask to be left alone which was respected", "transfer to theatre was quick, efficient and all staff were reassuring and calm", "staff have been amazing", "can't speak highly enough of staff and everyone have been caring and very thorough", "overwhelming breastfeeding and tongue tie support".

The bereavement midwife had engaged well with the Muslim elders and community in the local areas to provide necessary Muslim support packages needed by bereaved families, such as prayer beads, anointing oils and shrouds and list of Muslim funeral directors.

The service had carried out surveys and listening events for student midwives and doctors to get their feedback and created specific action plans. The students now had monthly forums and they had seen improvements around communication with staff.

The 2022 Trust NHS staff survey result highlighted that staff across various trust hospital departments felt they were valued, listened to, and supported by managers, however, these figures were slightly less than in the 2021 survey. The divisional staff survey result showed there were 9 actions for maternity which related to issues such as staff retention and recruitment and escalation of concerns. The action plan showed most of the actions were completed or in progress.

In the same staff survey result, the Workforce Race Equality Standards (WRES) data showed that staff from an ethic minority group had a poorer experience than white staff. The Workforce Disability Equality Standards (WDES) data showed that staff with long-term condition or illness had a poorer experience than other staff. During inspection, staff we spoke to reported good work experience, equal opportunity, career progression and felt supported by their managers and colleagues.

The service always made available interpreting services for women and birthing people and collected performance data on ethnicity, which was reviewed monthly in the maternity score card.

Learning, continuous improvement and innovation

Maternity

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. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. They had a quality improvement training programme and a 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 included participation in an ongoing national study of post-partum haemorrhage (PPH) (obstetric bleeding). The service also participated in the ongoing cerclage (a treatment that involves temporarily sewing the cervix closed with stitches) 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 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 at the trust's showcase events, such as for triage waiting time improvement, and bladder and pelvic health.

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 staff. As part of the project, the team also 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 who received the RCM 2023 'Partnership and Team Working' award.

The joint perinatal pelvic floor clinic had helped reduced the use of containment products in the community, which resulted in the savings 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 ICS 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 create awareness for staff on how service users from different backgrounds experience maternity care, and how cultural differences might impact on this.

A trust maternity support worker (MSW) 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 the 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.

Maternity

The trust was one of the four early adopter sites for the implementation of a clinical decision tool aimed at reducing the clinical impact of placental dysfunction and preterm birth, support provision of 'the right care at the right time', personalising risk assessment and care in line with best evidence and reducing inequity. Initial studies found use of the decision tool had reduced the chance of perinatal death for Black, Asian and ethnic minority women and birthing people.

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.

The maternity record project would provide women and birthing people with a platform to access their electronic records. This would support personalized care into the future, reduce risks associated with hybrid paper/digital documentation and improve data collection for national maternity audits and reporting compliance. The trust had seconded two midwives for a 9-month period to support the implementation of this project, with a go-live date of February 2024.

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

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

The maternity service had achieved the final UNICEF baby friendly level 3 status, which is considered gold standard to improve the infant feeding and relationship building experience of mothers and babies.

The trust was co-producing a research project led by the hospital local Healthwatch Greenwich to explore the experience of migrant women and birthing people in the maternity services that had given birth in the last 12 months. The project was funded by SEL LMNS, commissioners, local authorities and MVP working together to transform maternity services across Southeast London.

A clinical fellow had developed a recipe group for women and birthing people with gestational diabetes and had received input from the MVP to update the recipe. This ensured the recipe reflected the diverse cultural needs and tradition of people who accessed the service, including Afro-Caribbean and Eastern European.

The service had introduced a line management band 5 maternity support worker role, where the lead managed the band 3 and 4 support workers, which was in line with Health Education England recommendations. The band 5 staff had day to day supervisory responsibilities and delegated tasks to other junior support worker, evaluate their own and other's practice as well as suggest and implement changes to improve service delivery.

Outstanding practice

We found the following outstanding practice:

Maternity

- 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 QI project was a finalist in the Advancing Healthcare Awards 2023 for reducing the use of containment product in the community.
- The Lewisham maternity service was the first service in UK to be awarded the Gold Pride in Practice Award. The pride in practice is a national quality assurance training programme that strengthened and developed a healthcare providers' relationship with their LGBTQIA+ patients.
- 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.
- 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 maternity 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.
- As part of the 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 service had provided antenatal clinics in a hotel for pregnant Afghanistan refugees that arrived the country and were lodged a hotel within 24 hours.
- The Lewisham MVP in collaboration with the trust developed the cultural humility initiative to ensure expectant and new parents received high quality care during and after pregnancy regardless of their cultural backgrounds.
- The service and the maternity voice partnership (MVP) working together was exemplary, active, and engaged well with the service to drive improvement, service delivery, co-produce leaflets and involved in quality improvement projects.

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:

- The service should continue to address the vacancy rates in the service.
- The service should ensure staff complete and document fresh eyes observations in line with national guidance.
- The service should ensure staff complete daily checks of emergency equipment and cleaning records.

Maternity

- The service should ensure specialist staff have access to appropriate safeguarding supervision to carry out their duties.

Our inspection team

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