University Hospital Southampton NHS Foundation Trust

Princess Anne Hospital

Quality Report

Coxford Road
Shirley
Southampton
Hampshire
SO16 5YA
Tel: 023 8077 7222
Website: www.uhs.nhs.uk

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Maternity and gynaecology	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Princess Anne Hospital is part of University Hospital Southampton NHS Foundation Trust, which has had foundation status since 1 October 2011. The hospital provides maternity and gynaecological services, and is across the road from the main general acute hospital. Services are provided to the local community of Southampton City, and areas of Hampshire and the New Forest.

Neonatal services are also provided at this location but were inspected under services for children and young people , in the Southampton General Hospital location report.

The trust had 80 maternity beds. Midwife-led and obstetrician-led services are provided for early pregnancy, antenatal, induction of labour and postnatal care. There is an antenatal clinic and early pregnancy assessment unit, a four bedded day assessment unit and a four bedded induction of labour ward. Inpatient care is provided on Lyndhurst Ward (12 beds primarily used as antenatal beds, but often also housing postnatal women and babies) and Burley Ward (a 22 bedded postnatal ward). The Broadlands Birth Centre, a midwife-led unit near the main obstetrics unit, consists of four birthing rooms, two of which are equipped with pools and four postnatal beds for newly delivered mothers and babies. The delivery suite consists of 15 birthing rooms. One of these rooms is used as a bereavement room, one contains a pool, and there is a two bedded high dependency bay. The theatre suite adjacent to the delivery suite comprises of two obstetric operating theatres.

There is also a free standing midwife-led unit known as the New Forest Birth Centre, located in Ashurst on the edge of the New Forest. The unit has seven postnatal beds, three of which are single rooms, and two birthing rooms with pools. Findings from our inspection of this unit are included in this report on maternity services.

The gynaecology service is provided in a 21 bedded gynaecology and breast care ward (Bramshaw), a gynaecology outpatients area, and a two chaired hyperemesis unit.

The inspection was part of an announced trust-wide inspection which took place on 10 and 11 December 2014, with unannounced visits on 13 and 14 January 2015. The team inspecting this location included CQC inspectors and analysts, doctors (obstetrician and gynaecologists), head of midwifery and gynaecology, and midwives.

Overall we rated the Princess Anne Hospital as 'Good. We rated it good' for providing effective, caring, responsive and well-led maternity and gynaecological services. But it 'required improvement' under safe services.

Our key findings were as follows:

Is the service safe?

- Incidents were reported and lessons were learnt and shared to prevent the likelihood of reoccurrence.
- All areas were visibly clean, and staff were seen to adhere to good infection control and hand hygiene practices.
- Staff were supported to identify and support women and babies at risk. Risk assessments were undertaken and actions to reduce the likelihood of harm occurred.
- Hoisting equipment was available on Bramshaw Ward. But not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman that may have collapsed in a birthing pool on the delivery suite or at the Broadlands Birth Centre.
- There were two fully staffed obstetric theatres from 8am – 1pm every weekday. At all other times one theatre was immediately available for emergencies and a second team available to be called upon if the second theatre was needed.

Summary of findings

- One of the four operating tables could not be lowered adequately, and surgeons were required to stand on stools which increased the risk of back injuries to the surgeon and patient risks during surgery.
- The building was originally designed and built to provide a maternity service to 4,000 women and far fewer deliveries than the 5,812 births which took place between 1 April 2013 and 31 March 2014. As such, some areas were overcrowded, including the day assessment unit and the induction suite.
- Staff and patients told us some rooms in maternity services were cold ; we found windows were poorly fitted and single glazed which made them draughty.
- The funded midwife to birth establishment was 1:28 and was below the England average of 1:29. The RCOG also states that there should be an average midwife to birth ratio of 1:28. However, with sickness and maternity leave, the current ratio was 1:31. Midwives were being allocated to women to provide one to one care, but frequently worked in different areas in order to do so. As a result, midwifery staffing on the ante and postnatal areas was, at times, below the recommended numbers, and this had resulted in the care of women in these areas being delayed.
- The trust reported 98 hours dedicated consultant cover on the delivery suite, which fell below the recommended 168 hour consultant presence to meet the recommendations of Royal College of Obstetricians and Gynaecologists, Safer Childbirth (2007). There was a separate on-call rota for gynaecology and obstetrics, which meant medical staff were not required to provide cover to both areas. Consultants were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors.

Is the service effective?

- The care and treatment delivered to women was evidence-based. Policies and guidelines were developed in line with national guidance.
- Staff encouraged normal birth in the maternity service. The caesarean section rate was below the England average and the normal delivery rate was comparable to the England average This results in a higher than average number of assisted deliveries.
- A wide range of pain relief was available. Post-operative pain was managed with patient-controlled analgesia, polices existed to support the management of pain in the latent phase of labour, and women in labour had access to epidural anaesthesia at all times on the delivery suite.
- Staff received training and support to maintain their competence. The supervisor of midwives (SoM) ratio was 1:15, equal to the nationally recommended ratio. There was good, supportive multidisciplinary team working. Multidisciplinary clinics were held for women with complex care needs.
- The processes for women to consent were appropriate. Staff had appropriate knowledge of the Mental Capacity Act 2005, and there was support available in the event of a concern regarding a woman's capacity to make decisions.

Is the service caring?

- Care was seen to be delivered with kindness and compassion. Women were involved in decision-making, and staff ensured understanding and involvement of patients and their partners/relatives, and emotional support through good communication.
- Patients told us their experience of care was good. The NHS Friends and Family Test (FFT) response rates were in line or higher than the national average. The service performance dashboard indicated 98% of gynaecological patients were satisfied with the care they had received. Results for the maternity service for December showed 73.8% of women were extremely likely to recommend the service.

Is the service responsive?

Summary of findings

- Women were able to make choices on where to have their babies, with the choice of home, midwife-led care in a free standing birth centre, midwife-led care in an alongside birth centre or obstetric-led care. Women were also able to receive ante and postnatal care and support in the New Forest Birth Centre.
- There were two fully staffed obstetric theatres every weekday morning. At all other times one theatre was immediately available for emergencies. Access was delayed for non-emergency procedures, such as the repair of third and fourth degree perineal tears, but the number of delays had reduced with the opening of the second theatre in the morning.
- The provision of gynaecological care occurred within the 18 week referral to treatment (RTT) national target timeframe. Theatre slots were filled based on the needs of women, and regular theatre slots were allocated to the early pregnancy assessment centre to facilitate surgery within 24-48 hours if required.
- Women had access to information to support their diagnosis or pregnancy options. Some information was available in different languages.
- Translation services were available. Staff were able to access support for patients with additional needs, such as learning disabilities and mental health needs.

Is the service well-led?

- The maternity service was in the process of developing a new vision and strategy which would involve changes to the way midwives worked to deliver care. This had involved staff surveys and a listening event, with a plan to fully involve staff and service users in the onward development. A strategy for the gynaecology service was not developed.
- The service had a well-defined governance structure. Specialist midwives and administration staff were employed to support the governance function.
- Staff were positive about the support from the senior staff and immediate managers, and there were plans to support succession planning. Staff described an open culture which encouraged honesty, and were able to describe changes in practice as a result of this. Success was praised. Not all staff, however, felt connected with the main trust.
- Services were implementing a number of new innovations. The maternity service had worked with local universities to develop changes to the midwifery course to establish two cohort intakes per year from February 2016, in order to provide a steadier stream of new midwifery staffing to the service.

We saw several areas of outstanding practice, including:

- Midwives who held a caseload (named as caseload midwives) worked in areas of greatest deprivation and with the largest number of teenage pregnancies. These midwives had smaller caseloads and provided greater continuity of care, and often followed the women into the maternity unit to deliver.
- There was a 'birth afterthoughts' service which enabled women to have a debrief with a midwife following their delivery. Themes from this service were identified and fed into the governance process. Over 400 women had accessed the service during 2014.
- Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration. This meant they could remain at home and this helped to prevent admission.
- A telephone triage service with a neighbouring trust had been agreed and was about to be implemented. This initiative would direct women to the appropriate place for care.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure:

Summary of findings

- Operating tables can be lowered adequately, so surgeons are not required to stand on stools, increasing the risk of back injuries to the surgeon and patient risks during surgery
- Ensure all staff are aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools.

The trust should:

- Review acuity and midwifery staffing levels to ensure adequate care in all sectors of the service at all times.
- Review consultant cover on the delivery suite in line with RCOG, Safer Childbirth (2007).
- Review systems to ensure that all babies receive newborn examination checks in the appropriate time frame.
- Ensure that action is taken to improve temperature control in rooms in maternity services which were cold at times, with poorly fitted and single glazed windows which make them draughty.
- Ensure staff are aware of the how the new call bell system works, and that there are sufficient call bell panels for staff to ascertain location of emergencies.
- Review the times of provision of a dedicated second obstetric theatre, extending availability to further reduce delay in non-urgent procedures.
- Continue to review the facilities for the induction of labour, to ensure there is sufficient space and capacity to provide adequate privacy and dignity, and to meet demand and reduce waiting times for women.
- Review the provision of facilities for women and their partners to make drinks or have snacks on wards without the need to leave the wards to access vending machines.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Good	Maternity and gynaecological services were found to be effective, caring, responsive and well-led. The safety of services required improvement. Incidents were reported and lessons were learnt, and there were good infection control practices. Systems were in place to identify and support women and babies at risk. Risk assessments were undertaken and acted upon. Staff received training to support their roles. But not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman who might collapse in a birthing pool. Some areas of the hospital were visibly overcrowded, including the day assessment unit and induction suite. One out of four operating tables could not be lowered adequately, resulting in a risk to both the surgeon and woman during surgery, this was due to be replaced Funded midwife to birth establishment was 1:28 based on the national recommendation. The England average was 1:29. However, with sickness and maternity leave, the current ratio was 1:31, resulting in the need to move midwives frequently to different work areas. Most movement occurred in order to provide one to one care to women in labour. As a result, midwifery staffing on the ante and postnatal areas were, at times, below the recommended numbers. The 98 hours dedicated consultant cover on the delivery suite fell below the recommendations of RCOG, Safer Childbirth (2007). Consultants, however, were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors. Care and treatment delivered was evidence-based and multidisciplinary in its approach. The caesarean section rate was below the England average and the normal delivery rate was comparable to the England average This results in a higher than average number of assisted deliveries. A wide range of pain relief was available throughout the service. Staff received training and support to maintain their competence in all areas. The supervisor of midwives ratio was 1:15. Care was seen to be delivered with kindness and compassion. Women were involved in decision-making,

Summary of findings

and staff ensured understanding and involvement of patients and their partners/relatives and emotional support through good communication. Women were able to make choices on where to have their babies. Services were timely with 18 week referral to treatment targets met, and allocated theatre slots to prevent delay in accessing theatre for women who had suffered an early pregnancy loss. Translation services were available, and staff were able to access support for patients with additional needs, such as learning disabilities and women requiring additional support. Processes were in place to support the rapid transfer of women into the main hospital for further investigations or intensive care.

The maternity service was in the process of developing a new vision and strategy which would involve changes to the way midwives worked to deliver care. This had involved staff and there were plans for patient and public engagement. There was a well-defined process for monitoring activity, quality and risk, with specialist midwives and administration staff to support the function. Staff described an open culture which encouraged honesty where success was praised. Services were implementing a number of new innovations, including a telephone triage service with a neighbouring trust.

Good

Princess Anne Hospital

Detailed findings

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Maternity and gynaecology

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Detailed findings

Background to Princess Anne Hospital

The Princess Anne Hospital is part of University Hospital Southampton NHS Foundation Trust, which has had foundation status since 1 October 2011. The hospital provides maternity and gynaecological services, and is across the road from the main general acute hospital. Services are provided to the local community of Southampton City, and areas of Hampshire and the New Forest. Between 1 April 2013 and 31 March 2014, there were 5,812 births across the whole of the service.

The trust had 80 maternity beds. Midwife-led and obstetrician-led services are provided for early pregnancy, antenatal, induction of labour and postnatal care. There is an antenatal clinic and early pregnancy assessment unit, a four bedded day assessment unit and a four bedded induction of labour ward. Inpatient care is provided on Lyndhurst Ward (12 beds primarily used as antenatal beds, but often also housing postnatal women and babies) and Burley Ward (a 22 bedded postnatal ward). The Broadlands Birth Centre, a midwife-led unit near the main obstetric unit, consists of four birthing rooms, two of which are equipped with pools and four postnatal beds for newly delivered mothers and babies.

The delivery suite consists of 15 birthing rooms. One of these rooms is used as a bereavement room, one contains a pool and there is a two bedded high dependency bay.

There is also a free standing midwife-led unit known as the New Forest Birth Centre, located in Ashurst on the edge of the New Forest. The unit has seven postnatal beds, three of which are single rooms, and two birthing rooms with pools. Findings from our inspection of this unit are included in this report on the Princess Anne Hospital.

The gynaecology service is provided in a 21 bedded gynaecology and breast care ward (Bramshaw), a gynaecology outpatients area, and a two chaired hyperemesis unit. On site, gynaecological and breast theatres are run by the Women and Newborn Care Group at the hospital .

In addition to maternity and gynaecological services, the Princess Anne Hospital has a Level 3 neonatal intensive care unit and an orthopaedic ward. These were inspected as part of the services for children and young people, and surgical services, and contribute to findings detailed in the Southampton General Hospital location report.

Our inspection team

Our inspection team was led by:

Chair: Dame Eileen Sills, Chief Nurse, Guy's and St Thomas' NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team inspecting this location was part of the wider CQC inspection team of over 60 CQC inspectors, analysts, 'experts by experience' and a variety of specialists. The location inspection team included CQC inspectors and specialists, including obstetrician and gynaecologists, midwife and head of midwifery and gynaecology. (Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.)

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

We carried out an announced inspection visit on 10 December and 11 December 2014. We withdrew from the inspection on 11 December due to an outbreak of Norovirus at Southampton General Hospital, which resulted in closure of the hospitals to visitors, as a precautionary measure. We completed the inspection through unannounced inspections on 13 and 14 January 2015.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG); Monitor; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Southampton on 9 December 2014, when people shared their views and experiences of the University Southampton Hospital NHS Foundation Trust.

During the inspection of this location we spoke with 18 patients, three relatives and 58 staff. These included senior managers, midwives, nurses, specialist nurses, consultants, junior doctors, healthcare assistants, midwifery support workers, receptionists and housekeepers. We observed two shift handovers. We held a focus group attended by a further 27 staff. In addition, we reviewed nine patient's healthcare records.

We would like to thank all staff, patients, families and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Princess Anne Hospital.

Facts and data about Princess Anne Hospital

Key facts and figures

University Hospital Southampton NHS Foundation Trust (UHS) has had foundation status since 1 October 2011.

UHS has five active registered locations: Southampton General Hospital (SGH), the Princess Anne Hospital (PAH), Countess Mountbatten House (CMH), Royal South Hants Hospital and the New Forest Birth Centre.

It provides services to the population (1.9 million) of Southampton and south Hampshire.

1. Context

- The Princess Anne Hospital has approximately 100 beds (maternity beds, gynaecology beds, and birthing rooms). The New Forest Birth Centre has four beds.
- The local population is around 500,000, of which 100% is urban.
- Deprivation in the City of Southampton is higher than average (79 out of 326 local authorities). The surrounding areas of Eastleigh, Fareham, New Forest and Test Valley are less deprived.
- Life expectancy for both men and women is higher than the England average.

2. Activity

- 5,812 births; 5,495 deliveries were recorded between 1 April 2013 and 31 March 2014
- 98.5% being single births and 1.5% multiple births. This is the same as the England average. (Source: RCPCH, 2013)

3. Bed occupancy

- Maternity was at 52.62% bed occupancy – consistently lower than England average of 57.9%

4. **Individual risks/elevated risks:**

None identified by CQC for maternity and gynaecology services

5. Safe:

- 'Never events' in past year 0 (2013/14)
- Serious incidents (STEIS) 5 (2013/14)
- National reporting and learning system (NRLS) July 2013-Dec 2014; no evidence of risk

6. Effective: (December 2014)

- Hospital Standardised Mortality Ratio (HSMR): no evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): no evidence of risk (Intelligent Monitoring)

7. Caring:

Detailed findings

- CQC maternity service survey: similar to other trusts
- FFT inpatient: response rates were in line with or higher that the England average (2013/14)

8. Responsive:

- The unit was closed to admissions on three occasions between September 2013 – August 2014

9. Well-led:

- NHS Staff survey (30 questions)Better than expected (in top 20% of trusts) for nine questions; worse than expected for three questions; similar to expected for 18 questions

10. CQC inspection history

- The Princess Anne Hospital was inspected in December 2012 and was compliant with standards.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

<Notes here>

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The hospital provides maternity and gynaecological services to the local community of Southampton City, and areas of Hampshire and the New Forest.

The gynaecology service is provided in a 21 bedded gynaecology and breast care ward (Bramshaw), a gynaecology outpatients area, and a two chaired hyperemesis unit . On site, gynaecological theatres are run by the trust's surgical division.

Midwife-led and obstetrician-led services are provided for early pregnancy, antenatal, induction of labour and postnatal care. There is an antenatal clinic and early pregnancy assessment unit, a four bedded day assessment unit and four bedded induction of labour ward. Inpatient care is provided on Lyndhurst Ward (12 beds primarily used as antenatal beds, but often also housing postnatal women and babies) and Burley Ward (a 22 bedded postnatal ward with the facility to provide some transitional care). The Broadlands Birth Centre, a midwife-led unit near the main obstetric unit, consists of four birthing rooms, two of which are equipped with pools and four postnatal beds for newly delivered mothers and babies. The delivery suite consists of 15 birthing rooms. One of these rooms is used as a bereavement room, one contains a pool and there is a two bedded high dependency bay. In addition, there is a free standing midwife-led unit known as the New Forest Birth Centre, located within the New Forest. The theatre suite adjacent to the delivery suite comprises of two obstetric operating theatres.

Obstetric and specialist clinics are run by obstetricians and other specialist consultants (for example, a diabetologist and anaesthetists). Antenatal clinics are held Monday to Friday at the Princess Anne Hospital. Clinics are also held in various settings across the community, including the New Forest Birth Centre.

Between 1 April 2013 and 31 March 2014, there were 5,812 births across the whole of the service.

During the inspection we spoke with 18 patients, three relatives and 58 staff. These included senior managers, midwives, nurses, specialist nurses, consultants, junior doctors, healthcare assistants, midwifery support workers, receptionists and housekeepers. We observed two shift handovers. We held a focus group attended by a further 27 staff. In addition, we reviewed nine patient's healthcare records.

Maternity and gynaecology

Summary of findings

Maternity and gynaecological services were found to be effective, caring, responsive and well-led. The safety of services required improvement.

Incidents were reported and lessons were learnt, and there were good infection control practices. Systems were in place to identify and support women and babies at risk. Risk assessments were undertaken and acted upon. Staff received training to support their roles. But not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman who might collapse in a birthing pool.

Some areas of the hospital were visibly overcrowded, including the day assessment unit and induction suite. One out of four operating tables could not be lowered adequately, resulting in a risk to both the surgeon and woman during surgery, this was due to be replaced.

Funded midwife to birth establishment was 1:28 based on the national recommendation. The England average was 1:29. However, with sickness and maternity leave, the ratio was 1:31, resulting in the need to move midwives frequently to different work areas. Most movement occurred in order to provide one to one care to women in labour. As a result, midwifery staffing on the ante and postnatal areas were, at times, below the recommended numbers. The 98 hours dedicated consultant cover on the delivery suite fell below the recommendations of RCOG, Safer Childbirth (2007). There was a separate on-call rota for gynaecology and obstetrics, which meant medical staff were not required to provide cover to both areas. Consultants were, however, present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors.

Care and treatment delivered was evidence-based and multidisciplinary in its approach. The caesarean section rate was below the England average and the normal delivery rate was comparable to the England average This results in a higher than average number of assisted deliveries. A wide range of pain relief was available throughout the service. Staff received training and support to maintain their competence in all areas. The supervisor of midwives ratio was 1:15.

Care was seen to be delivered with kindness and compassion. Women were involved in decision-making and staff ensured understanding and involvement of patients and their partners/ relatives, and emotional support through good communication. Women were able to make choices on where to have their babies.

Services were timely, with eighteen week referral to treatment targets met, and allocated theatre slots to prevent delay in accessing theatre for women who had suffered an early pregnancy loss. Translation services were available, and staff were able to access support for patients with additional needs, such as learning disabilities and women requiring additional support. Processes were in place to support the rapid transfer of women into the main hospital for further investigations or intensive care.

The maternity service was in the process of developing a new vision and strategy, which would involve changes to the way midwives worked to deliver care. This had involved staff, and there were plans for patient and public engagement. There was a well-defined process for monitoring activity, quality and risk, with specialist midwives and administration staff to support the function. Staff described an open culture which encouraged honesty, where success was praised. Services were implementing a number of new innovations, including a telephone triage service with a neighbouring trust.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement.

Hoisting equipment was available on Bramshaw Ward. But not all staff were aware of the location or correct use of equipment for the safe evacuation of a woman that might collapse in a birthing pool on the delivery suite or at the Broadlands Birth Centre. Not all staff were fully familiar with the difference between the old and new call bell system. An additional control panel identifying location of emergency was needed on the labour ward.

The building was originally built and designed for far fewer deliveries. As such, some areas were overcrowded, including the day assessment unit and the induction suite. One out of four operating tables could not be lowered adequately. As a result, surgeons were required to stand on stools, which increased the risk of back injuries to the surgeon and patient risks during surgery.

There was not a clear system in place to evidence that all babies received newborn physical examinations in the appropriate time frame.

Funded midwife to birth establishment was 1:28; however, with sickness and maternity leave, the current ratio was 1:31. There were core midwives who were allocated to different areas. Midwives then followed women to provide their care. As a result, midwives reported frequent moves to different work areas. Most movement occurred in order to provide one to one care to women in labour. As a result, midwifery staffing on the ante and postnatal areas was, at times, below the recommended numbers. This resulted in care being delayed.

The trust reported 98 hours dedicated consultant cover on the delivery suite, which fell below the recommended 168 hour consultant presence to meet the recommendations of RCOG, Safer Childbirth (2007). There was a separate on-call rota for gynaecology and obstetrics. This meant medical staff were not required to provide cover to both areas. Consultants were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctor.

There were two fully staffed obstetric theatres from 8am – 1pm every weekday. At all other times one theatre was immediately available for emergencies and a second team available to be called upon if the second theatre was needed.

Incidents were reported, and lessons were learnt and shared to prevent the likelihood of reoccurrence. All areas were visibly clean and staff were seen to adhere to good hand hygiene practices. Staff were supported to identify and support women and babies at risk. Risk assessments were undertaken and actions put in place to reduce the likelihood of risks occurring.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system which was available in the clinical areas, and told us they were confident to report incidents. Systems for incident reporting were described as quick and simple, which staff said enabled them to promptly report incidents. Staff who were uncomfortable with the use of computers were able to describe how they would escalate an incident to ensure it was reported by other staff.
- There was a trust-wide list of incident categories and maternity-specific categories. This gave staff clear guidance on what constituted an incident. The electronic information system used for reporting labour and birth details had been designed to automatically flag incidents of concern, such as higher than normal blood loss.
- Incidents recorded included any unplanned admission to the neonatal unit, post-partum haemorrhages, and third and fourth degree tears. Data for 2013-14 showed an average of 3.2% of babies born over 37 weeks gestation and weighing greater than 2.5kg were admitted to the neonatal unit (and therefore as unplanned), below the England average of 4%. Rates for post-partum haemorrhage in excess of 1.5 litres for the year to date were recorded on the birth outcomes report for October 2014 as 3.6%. 3.6% of women experienced a third or fourth degree tear, lower than the England average as reported by RCOG. There were ongoing actions underway to attempt to lower this further.

Maternity and gynaecology

- Every morning the labour ward co-ordinator, obstetric consultant and a supervisor of midwives reviewed the previous day's maternity flagged incidents and, where necessary, gave immediate feedback to staff. This feedback was often to praise staff for managing incidents well.
- When required, other staff were called to attend the daily event review. These included anaesthetists, paediatricians or neonatal nurses. Staff said this ensured a multidisciplinary approach to the review and oversight of incidents.
- A range of incident review meetings were held. These included clinical incident discussion meetings which were facilitated twice a month. Midwives described 'Red Reviews' which were held once a month. Clinical incidents in birth centres were reviewed in meetings facilitated by a consultant midwife. Staff on the delivery suite described having 'hot debriefs'. These occurred at the end of shifts during which a serious incident or significant clinical event had occurred. A proforma-led rapid debrief session was facilitated for all staff involved, to ensure all aspects of debrief were covered. Staff told us this prevented them going home and worrying unnecessarily. We saw evidence these incident review meetings had occurred, with praise to staff who had facilitated them.
- Clinical incidents were reported and monitored at the divisional Women and Newborn Clinical Governance Steering committee. This was linked to the trust Quality Governance Steering Group. Serious incidents involving multiple agencies and services were thoroughly investigated, with learning fed back into all organisations involved, as well as other divisions. For example, we saw learning had been shared with the ambulance service following an incident during the transport of an acutely ill woman.
- A perinatal morbidity and mortality meeting was held monthly. We saw minutes of the last meeting, which showed a critical appraisal of events. One case had raised a concern that recent changes to paperwork had not allowed fetal growth to be easily tracked. In response, records had been changed to ensure if foetal growth was slowing down it could be more easily seen. Lessons learnt were also on a noticeboard on the delivery suite. Staff were familiar with changes to practice as a result of learning from incidents.
- Staff received personal invites to meetings and reviews for cases they had been involved in. Attendance was also open to everyone in order to facilitate learning.
- Lessons learned from incidents were shared with staff via email, newsletter and through a highlighted theme of the week. For example, we saw themes had included latent phase management and the trust's missing baby policy.
- Learning from incidents was also evident in the gynaecological inpatient wards. Incidents were reviewed and evaluated, and action plans developed. These included incidents for falls and medicines errors. Other incidents were reviewed at morbidity and mortality meetings. Findings and lessons learnt were discussed at team meetings.
- Staff were able to describe changes in practice that had occurred as a result of learning from a clinical incident, such as the development of a form to facilitate triage of women attending the maternity assessment unit.
- The trust monitors areas of poor quality or low reporting. For example, they had worked closely with obstetrics, to improve incident reporting. Training was provided, managers were required to take ownership of the quality of incident reports, and a consultant obstetrician was added to the steering group. This has improved the level of incident reporting, and the quality of advice and challenge.

Duty of Candour

- Staff were aware of the Duty of Candour and told us how women were informed on incident investigations and outcomes. Serious incident investigations detailed how patients and relatives had been informed and supported throughout the investigation.

Safety thermometer

- The gynaecology ward participated in the NHS Safety Thermometer, and collected information in respect to patient falls, catheters, urinary tract infections, and pressure ulcers, which were in line with the England average. The maternity service did not participate in the Safety Thermometer, but instead monitored other safety data felt to be more relevant to maternity services. Patient safety information was not displayed in clinical areas.

Cleanliness, infection control and hygiene

- All areas were visibly clean. Staff were seen cleaning equipment after use and there were 'I am clean' stickers in use on some items to indicate an item was ready to be used again. However, the stickers were not used consistently across the service. Staff at the New Forest Birth Centre told us they did not apply stickers as they wished to maintain a 'home from home' environment but they reviewed the cleanliness of equipment daily. We saw evidence of some equipment being checked for cleanliness (such as resuscitaires).
- Hand hygiene gel was available at the entrances to the wards, departments and the New Forest Birth Centre. They were also present within each birthing and examination room.
- Staff were seen to be 'bare below the elbows' in clinical areas in accordance with the trust infection control policy, and were observed washing their hands prior to and after carrying out patient care.
- Aprons and gloves were readily available, and we saw staff used them when carrying out the specific duties for which they were required.
- The service had been involved with patient-led assessments of the care environment (PLACE). This involved teams assessing how the care environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. Scores for the assessment during 2013 rated maternity cleanliness at 99.73%.
- We saw posters around the hospital advising patients and visitors of the recent outbreak of Norovirus, and restrictions regarding visiting, and hand hygiene guidance. Staff were seen to follow the trust infection control procedure to prevent the spread of infection. During our inspection a patient was identified as possibly contracting Norovirus. The staff implemented the isolation procedure in the bay where this patient and three others were accommodated until the result was known.
- Women contacting the maternity unit prior to admission were asked questions regarding their risk of exposure to both Norovirus and Ebola. In addition, the maternity service had made a decision to limit birth partners to one, in order to reduce the risk of Norovirus being brought into the unit from the wider community.
- During the inspection, a chair was noted in the anaesthetic room which had been held together with tape, making effective cleaning difficult. We raised this as a concern at the time. During the unannounced inspection, we noted that the chair had been removed from use.
- Cleanliness audits in December 2014 showed 100% compliance.

Environment and equipment

- Resuscitation equipment was available on the wards, and equipment such as oxygen and suction machines were checked daily. On Bramshaw Ward, the emergency resuscitation trolley had a seal to monitor risk of tampering. The seal was replaced on a weekly basis following checks of drawers and medicines to ensure they were in date and fit for purpose. We saw completed check lists which demonstrated emergency resuscitation equipment was checked at least daily and following each use. Emergency equipment for the management of post-partum haemorrhages was available in all birthing areas.
- Patients on Bramshaw Ward, who required hoisting, were issued with individual slings. These were disposable slings used for the prevention and control of infection. A hover jack hoist was shared between the wards for safe moving and handling of bariatric patients.
- We were alerted to the presence of asbestos in the fabric of the building by visitors who had been concerned by stickers they had seen on the windowsills on Lyndhurst Ward. We discussed the issue with senior managers, who told us the stickers were to alert contractors only, and the asbestos posed no risk to patients. They described the additional work and time needed to conduct maintenance and environmental changes due to its presence.
- Some areas of the maternity unit had recently been refurbished. A new call bell system had been introduced by the trust in 2014. With the old system a light shone outside the room where assistance was required and there was a system of lights at each junction of corridors to show which corridor the room was in. Some staff were concerned that new signage was obscuring these emergency lights. The trust later explained these were now redundant and it was taking staff some while to get used to the difference. The new system in place had noise and lights to alert staff that help was required,

however, they needed to look at a panel in order to see which room required assistance. There were two panels and the trust told us staff felt that in an emergency another panel was required, and this had been ordered.

- Rooms in the New Forest Birth Centre were spacious. Each of the two delivery rooms were equipped with pools and emergency evacuation equipment for use in the event of a maternal collapse in the pool. Each also had a birthing ball and mat.
- Rooms on the delivery suite within the Princess Anne Hospital were more cramped, and there were limited additional facilities, such as birthing balls and mats, due to limited space. Staff described rooms becoming more crowded with equipment following an increase in the use of computer technology. Each room contained a computer on wheels, as well as all necessary birth equipment. Resuscitaires were kept within easy access just outside and were brought in as the woman delivered.
- At the Princess Anne Hospital, there was one birthing pool room in the delivery suite for women to labour and deliver their baby. This room did not have emergency evacuation equipment for use if a woman collapsed. Staff told us evacuation equipment (a net) could be obtained from the Broadlands Birth Centre, which was located on the floor above. The trust later told us that a pat slide for safe evacuation was kept in the treatment room. The Broadlands Birth Centre had two pools. There was one emergency evacuation pat slide shared between the two rooms. However, not all staff we spoke with were aware of their location.
- Staff being unaware of the location of the equipment on the Broadlands Birth Centre, increased risks, by delaying the ability to access and use emergency equipment when required. .One staff member described evacuating one woman from the pool using her own physical strength. This practice had the risk of injury to both woman and midwife. We immediately raised our concerns, regarding the safe and effective evacuation of women from the pools on both the delivery suite and at the Broadlands Birth Centre, with the midwife in charge at the time of the inspection.
- Areas within the maternity service were described by staff and patients as being cold at times. We identified some windows were poorly fitted and single glazed, which made them draughty. We noted an incident report where rooms on the delivery suite had been too cold to use, and women in labour had been moved to warmer rooms to reduce the risk of a newborn baby becoming cold. The trust told us that this problem had now been resolved.
- Doors into all wards were locked, with a buzzer entry system. The receptionist's desk was at the entrance to Lyndhurst and Burley Wards. However, the door could not be seen from the reception desk at the Broadlands Birth Centre. Visitors to the birth centre walked past a mother and baby area before getting to the desk. This presented a potential security risk to mothers and babies. In order to leave the unit, staff and visitors had to press a door release button. The Missing Baby Policy had been effectively activated and shown to have worked well recently when a father walked out of the hospital with his baby, to have a cigarette.
- There were two fully staffed obstetric theatres from 8am – 1pm every weekday. At all other times one theatre was immediately available for emergencies and a second team available to be called upon if the second theatre was needed. More pressing emergencies were prioritised into the one theatre immediately available. Trust data showed 90% of the category one sections were born within 15 minutes of the decision being made with 19 minutes being the longest decision-delivery interval.
- One out of four operating tables could not be lowered adequately to operate on bariatric patients. As a result, surgeons were required to stand on stools. This increased the risk of back injury to the surgeon, as well as risks to the patient during surgery. At the time of the inspection there was one bariatric table in use so two theatres were not compliant.
- There was a 'cell saver' available in theatres. This medical device can be used to re-infuse a patient's lost blood during haemorrhage. This provides a safe and immediate transfusion for all patients, and is an option for patients who are Jehovah's Witnesses. Staff with the skills to use this equipment were available at all times in the event of an emergency.
- We reviewed service data and electrical testing data on a range of equipment, such as scales, pumps, monitoring equipment and resuscitaires. We noted these had been serviced within the last twelve months.
- Staff reported a lack of equipment at times, citing particular shortages of hand held fetal monitors. Staff told us, at times, fetal cardiotocograph (CTG) machines were taken from Lyndhurst Ward for use in the delivery

suite, as there were insufficient machines to meet peak demand. However, staff on the delivery suite did not report this as a problem, and managers reported sufficient equipment provision.

Medicines

- Medicine cupboards were locked on all wards and departments. The medicine fridge on Bramshaw Ward was locked; however, only one of the two medicine fridges, both at the Broadlands Birth Centre and on the delivery suite, were locked. The fridge housing medicines for use in the event of a major haemorrhage was unlocked in both areas. Staff told us this was in order to have immediate access in the event of an emergency. (A post-partum haemorrhage is a significant obstetric complication.) This fridge was housed in an unlocked treatment room accessible to staff, but also potentially accessible to members of the public present on the delivery suite or at the birth centre. The trust was aware of this risk, assessments were in place and it was on the estates plan to be rectified in March 2015. Following the inspection we were told doors to the treatment room had been fitted.
- The New Forest Birth Centre had two fridges for medicine stocks. During the inspection, due to the malfunction of one of these and whilst awaiting replacement all the medicines were stored together in one fridge, which was unlocked. We raised this as a concern with the midwife in charge at the time of the inspection, and the drugs were removed and placed in a sealed tagged black box in the birthing room awaiting replacement fridge.
- There were processes for checking the drug fridge temperature and we observed this was recorded daily.
- Some staff on Bramshaw Ward told us accessing necessary and urgently required medication was a "major problem" between 6pm on a Friday and 9am on Monday. We spoke with the pharmacy manager, who assured us medicines were readily available and there was an on-call pharmacy system. Other nurses who did not raise this as an issue were clear about the procedures on how to access the pharmacist and drugs out of hours. There was on site pharmacy support, Monday-Friday, 9am-5pm.
- Staff described a recent incident when intravenous fluids were not available at the weekend. This had an impact on patient care, and resulted in staff obtaining intravenous fluids from the main hospital site.

Records

- Records reviewed contained all relevant risks assessments, such as venous thromboembolism (VTE), falls and pressure ulcer risks.
- VTE risk assessments were conducted for women accessing the gynaecological services during pre-assessments. This information was transferred on to the electronic system once the patient was admitted.
- Women carried their own records for the duration of their pregnancy. Maternity records contained pre-printed pathways, which were a clear way of directing staff as to the appropriate care to be given. For example, women who had a previous caesarean section were given a set of notes with specific details of the risks and benefits of vaginal delivery for subsequent pregnancies.
- Once delivered, women were issued with postnatal records for their care to be documented, and the child health record. These were completed by the midwife or midwifery support worker at subsequent visits.
- Babies were issued with the child health 'red book' once delivered. We observed midwives completing them.
- Access to post medical records was described as good. Consultants told us they always had access to the notes they required and described a "brilliant" system, where any written notes were scanned or typed into the electronic system. Whilst awaiting access to past written notes, staff could access old investigation results electronically.
- Pre-printed stickers were used, which gave prompts for staff to complete, such as the date and time of admission staff signatures. Cardiotocograph (CTG) stickers were used to record aspects of the fetal heart trace, and staff used stickers to record fetal blood sampling. This was a recent change, as a result of learning from the outcome of audits.
- Most women were happy with their records and staff record keeping; however, one woman described record keeping as "abysmal". Examples were given which included attendance at several outpatient clinics, during which the doctor updated the electronic records. However, this information was not entered in the antenatal handheld notes. This meant the community midwife never knew the outcome of the previous consultations and impacts on care.

- Most records reviewed were complete; however, one set of notes had incomplete information on the admission and history taking sticker, was not dated, and the surgical safety checklist did not contain the signature of the person who had signed out the instruments.
- Midwives conducted audits of recordkeeping as part of their annual supervisory review. Their records were audited and reviewed by their supervisor of midwives, and any remedial actions identified.
- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) records were completed and submitted to the Department of Health as required.

Safeguarding

- Patients we spoke with told us they felt "very safe", and received care and treatment that met their needs.
- Staff had received training in safeguarding and recognising abuse. They were confident to raise any matters of concern, and escalate as appropriate if they felt no action was taken.
- Senior nurses on Bramshaw Ward received training about domestic abuse from 'leader's days', run by accident and emergency department staff, which they reported as being informative and beneficial.
- Staff on Bramshaw Ward knew where to access safeguarding information and a flow-chart was provided to assist in referrals. There was a safeguarding lead nurse on the ward, but if this person was not available the safeguarding midwives were contacted for advice.
- The maternity unit employed safeguarding midwives, as well as midwives specialising in domestic abuse, substance misuse and mental health issues. Midwives described an "open door" culture which enabled easy access to specialist advice. There were four caseload teams across the city. Caseload midwives worked in areas of greatest deprivation and with the largest number of teenage pregnancies. The midwives had smaller caseloads (approximately 36, compared to the rest of the service which had approximately 80-90 women). The teams provided greater continuity of care and often followed the women into the maternity unit to deliver.
- Midwives also had close links with the Family Nurse Partnership who provided ongoing care beyond that within the remit of the midwife (until the babies second birthday) for all women aged under 19.
- There were systems in place to identify women and babies at risk. Midwives attended safeguarding case conferences and strategy meetings, and records were made to ensure concerns amongst midwives, obstetricians and paediatricians providing care were communicated amongst staff.
- Midwives received level three safeguarding training, with annual updates. Training data provided by the trust showed 91.7% of staff had received training and were up to date, with individual team compliance ranging from 85.7% to 100%
- We spoke with one of the two part time specialist safeguarding midwives. They described joint working protocols with external agencies. A key part of these were to establish agreed timelines so that assessments could be made at the most effective time. They had close links with the named paediatrician for safeguarding and the family support workers in the neonatal unit. They also attended the MASH (Multi Agency Safeguarding Hub) in both Southampton City and Hampshire, acknowledging that women at risk of having their child taken into the care of social services often moved around. Attendance in both areas was one way of mitigating against the risk that this brought.
- In addition to the MASH records completed, a form specifically designed to maintain greater detail for the maternity services had been developed and was in use.

Mandatory training

- Midwives told us their mandatory training could be cancelled occasionally as the unit was too busy and they were required to work clinically. We saw from the 'Maternity Dashboard' that this had happened to five midwives in May 2014 and 10 midwives in June 2014. Mandatory training had been cancelled for the month of January 2015 as a result of a predicted peak in activity. Midwives confirmed they were able to attend the required training within three months of sessions being cancelled.
- Staff completed the trust mandatory training. In addition, all midwives and obstetricians undertook multidisciplinary The Practical Obstetric Multi-Professional **Training (PROMPT))** skills drills training in obstetric emergencies. This is an evidence based training package that teaches healthcare

professionals how to respond to obstetric emergencies. The course has been found to be associated with improved clinical outcomes and reduced patient safety incidents.
- Department level training figures were not reported on dashboards. Figures were only available for trust-wide training compliance, which indicated training undertaken to be within their accepted limits.

Assessing and responding to patient risk

- All patients were assessed for venous thromboembolism (VTE). Patients were assessed at pre-assessment clinics or on admission, and risk assessments were updated daily. Patients were given information on VTE prevention as part of the discharge process.
- Within the maternity unit in December 2014, 97.3% of women in receipt of midwife-led care and 92% of women in receipt of obstetrician-led care, received VTE assessment. All notes for those women identified as not risk assessed were reviewed. As a result of this, staff had identified women who were admitted in early labour and then subsequently discharged to establish in active labour were most likely not to receive a risk assessment. A full audit was planned to support this belief.
- We saw records contained VTE, falls, nutritional and skin integrity risk assessments on Bramshaw Ward.
- Staff completed early warning scores for all patients on Bramshaw Ward, and deteriorating patients were seen by the hospital's outreach team who were reported to attend promptly when requested.
- In the case of midwifery and obstetrics, staff completed the modified early obstetric warning score (MEOWS) system to record observations. This was being used as standard, not just for women who were high risk or had become unwell. A newly qualified midwife explained said "it enables us to see trends or changes to a baseline".
- High dependency care was provided as required on the delivery suite. Only midwives who had undertaken, or were in the process of undertaking, additional training were allocated to work in the area.
- Midwives on the delivery suite practiced 'fresh eyes', where a different midwife periodically reviewed foetal wellbeing in labour to ensure abnormalities in the fetal heart trace had not been missed. The details of any unwell pregnant women admitted to other wards in the hospital were added to the labour ward handover board, so that their review by an obstetrician was not missed. This also ensured the labour ward co-ordinator knew that a midwife needed to be sent to assess fetal wellbeing. The women in the high dependency area were discussed first. This ensured staff knew any necessary information about them first, in case they were called away.
- Handovers began with general messages, followed by any necessary information about each woman on the ward. Each case was discussed in a consistent way. Concerns were talked about in a professional manner, such as when to refer to the Perinatal Mental Health Team; despite the location of the meeting being on the delivery suite, any women of concern on the gynaecological wards were also discussed by the medical team. In addition, handovers included details of the availability of cots in the neonatal unit and beds on the postnatal wards.
- Theatre lists were prioritised around patient risk. For example, we saw one diabetic patient planned for surgery in order to minimise the length of time they were nil by mouth.
- Midwives explained how women requiring treatment at the main hospital were managed in order to mitigate against risks. For example, a haemorrhaging woman would be stabilised on site, and transferred by ambulance to the main hospital if she required interventional radiology, or transfer to intensive care.
- Since June 2014, the hospital's paediatricians had not carried out the newborn examination for babies unless they did not fit the criteria for midwives to undertake. The examination checks for heart murmurs and many other abnormalities. It should be performed within the first 72 hours of life, optimally within the first 24 hours and should not usually be performed before six hours of age Whist many midwives had been trained to carry out the examination, there had been no additional funding to backfill their time. Some women elected to leave hospital before the examination had occurred. As a result, these examinations were either carried out by a suitably skilled community midwife, or the women had to attend the hospital or the New Forest Birth Centre to have their babies checked. There was not a clear system in place to ensure that all babies received these checks in the appropriate time frame.

Midwifery and Nurse Staffing

Maternity and gynaecology

- On Bramshaw (gynaecology) Ward, patients told us there were adequate numbers of staff and they did not "wait long" when they requested help. Staffing levels were displayed on the ward. The safe staffing information indicated there were the expected numbers of staff on each shift when we inspected.
- Patients told us the staff were busy, but very attentive. One patient commented "the staff take their time to explain things" and "you never feel rushed".
- Staff told us they had busy times, but there were always adequate staff.
- The acuity of patients on Bramshaw Ward was reviewed every two months, and this could result in the ward receiving an extra nurse to assist for a temporary period.
- The funded midwife to birth ratio was 1:28, though with sickness and maternity leave, the current rate was 1:31. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) states there should be an average midwife to birth ratio of 1:28. The England average was 1:29. Staff reported they were providing one to one care in labour, though staff did not complete an acuity tool to be able to demonstrate this.
- The maternity unit was staffed with a 'core' group of midwives. Other midwives worked as integrated midwives, providing ante and postnatal care in the community and on the wards, a home birth service, and attending women in labour on the delivery suite and at the Broadlands Birth Centre. In addition, there were midwives who had a caseload (caseload midwives) who worked in areas of greater deprivation, with higher teenage pregnancy rates, who provided all aspects of care to the women on their caseload, including intrapartum care. At the start of each shift the integrated midwives rang the operational co-ordinator to ascertain where they were needed to work. The operational co-ordinator was a midwife who had total oversight of the maternity service, activity, acuity and staffing numbers.
- Core and integrated midwives were frequently moved to provide cover in the area of greatest risk, which in most cases was the delivery suite, and was part of the processes to follow when activating the escalation policy. At times this left other areas with fewer midwives than optimum. We reviewed incident reports and noted there were occasions when only one midwife was left on a ward, observations had not been conducted, medicines had been late, and inductions of labour postponed due to a lack of staff. This put mothers and babies at risk. For example, midwives described occasions when one of the two midwives on Lyndhurst or Burley Wards had to leave to assist on the delivery suite. At times this left two midwives, supported by two maternity support workers and a nursery nurse, to care for up to 44 women and babies, some of whom were high risk. One woman told us Lyndhurst Ward could "appear short-staffed" when the ward was full and a midwife had to go to work on the delivery suite. On one occasion she described having to wait 25 minutes for the call bell to be answered.
- Managers acknowledged moving midwives to the delivery suite or the birth centre could leave other areas short of midwives, and could have an impact on sickness rates, as midwives felt anxious working in unfamiliar areas. Midwives told us, when they were asked to work on wards which they had little experience of, it could be daunting and sometimes problematic. For example, some midwives who were not yet confident with the new technology struggled with medicine rounds on postnatal wards using the e-Prescribing and Medicines Administration System (ePMS). In order to reduce the movement of midwives to the target of less than 10% of the time, ideas were being gathered from staff through a 'Listening Event' and a request to the trust board had been made for additional midwives.
- There were clear escalation processes in place when more midwives were identified as being required. This included additional support from the senior midwifery team and supervisors of midwives. The on-call rota for each of these processes was evident within the delivery suite. Staff described managers as willing to attend. Activation of the escalation policy was incident reported and reviewed.
- Agency midwives were unavailable locally; however, the trust had their own bank of staff and offered additional payments for extra hours or overtime worked.
- There was a supportive occupational health department with whom the maternity unit worked closely. This was done to maintain contact with staff while they were off sick and to manage phased returns to work.

Medical staffing

- There was 24 hours consultant cover, with a separate consultant rota for obstetrics and gynaecology. The delivery suite had 24 hour anaesthetic presence.

Maternity and gynaecology

- A consultant was available in clinics to offer support and advice to junior doctors. They told us the consultants were supportive and they had a good relationship. We observed on two different occasions during the gynaecological clinics where consultant advice was effectively sought.
- The maternity dashboard for November 2014 reported 98 hours dedicated consultant cover on the delivery suite. This was below the recommended 168 hour consultant presence to meet the recommendations of RCOG, Safer Childbirth (2007); however, staff told us consultants were available and on site during the day and attended when called out of hours.
- There was a separate on-call rota for gynaecology and obstetrics. This meant medical staff were not required to provide cover to both areas.
- Consultants were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors

Major incident awareness and training

- Staff were aware of processes to follow in the event of a major incident. The trust-wide major incident policy was available to all staff on the intranet.

Are maternity and gynaecology services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rate effective as good.

Care and treatment delivered was evidence-based. Policies and guidelines were developed in line with national guidance. Staff encouraged normal births. The caesarean section rate was below the England average and women were encouraged to consider vaginal birth after caesarean section; however, the normal delivery rate after caesarean section was below the England average.

A wide range of pain relief was available. Post-operative pain was managed with patient-controlled analgesia, where women could self-administer pain relief. Polices existed to support the management of pain in the latent phase of labour, and women in labour had access to epidural anaesthesia at all times on the delivery suite.

Staff received training and support to maintain their competence. The supervisor of midwives ratio was 1:15, equal to the recommended ratio. There was good, supportive multidisciplinary team working.

Consent processes were undertaken appropriately, with support available in the event of a concern regarding a woman's capacity to make decisions.

Evidence-based care and treatment

- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and RCOG guidelines, Safer Childbirth (2007). Trust and specialist policies were available for staff to access on the trust intranet site. These were subject to review and were up to date.
- The service promoted normal birth as much as possible and where appropriate. The clinical director spoke of good working relationships with midwives in order to promote this. However, the normal birth rate reported on the service dashboard was 59.4% for quarter 2. This was lower than the national average of 61.7%. Caesarean section rates were below the national rates at 23.7%. The induction of labour rate was about equal to the national average, but the number of assisted deliveries was high. Staff we spoke with were unclear of the reasons for this.
- The maternity used a document entitled Optimal care standards for promoting normal birth. The document gave clear guidance on how care should be provided. For example, a woman in labour should be encouraged to drink at least every hour to avoid dehydration which could slow labour.
- Women who had previously had a caesarean section delivery discussed their options for VBAC (vaginal birth after caesarean) with a consultant midwife, rather than automatically having their care transferred to a consultant obstetrician. Antenatal records had recently changed to incorporate information on VBAC throughout, rather than being given as a separate leaflet. Staff felt women would be more likely to read it and consider VBAC as a delivery option.
- Skin-to-skin contact between mother and baby was encouraged immediately after caesarean section, in line

with NICE Clinical Guideline 190, Intrapartum care: care of healthy women and their babies during childbirth. This practice regulates the baby's breathing and heart-rate, maintains their body temperature, and encourages bonding and breastfeeding.

- Hand-held records contained a prompt to ask women about their 'psychological wellbeing' during booking at 16, 25, 28 and 31 weeks. These had all been completed in records we reviewed.
- Babies born with tongue tie were seen in midwife-led clinics. Several midwives had been trained to undertake a procedure to cut the tie.
- There was an active audit programme with findings presented, and practice was being changed as a result of audit. For example, women who had a third or fourth degree tear at delivery requiring follow-up for rectal function were previously required to attend for a scan and follow-up appointment with a consultant at six to eight months post-delivery. Audit had identified that not all women had received a follow-up. As a result, the system had been changed to provide women with a 'one stop' appointment which enabled scan and review to occur together. Another example involved the development of an electronic referral system. This was used by the 'Optimum weight in pregnancy' midwife to facilitate bariatric assessment and optimum weight advice.

Pain relief

- Gynaecological patients we spoke with were positive about how their pain was managed. Pain relief options were discussed at pre-assessment clinics.
- Nurses assessed patient's pain regularly, and patients reported they had access to pain relief when needed. We spoke with one patient on Bramshaw Ward who was in control of her own post- operative pain relief through means of a PCA (patient-controlled analgesia) pump. They told us there had been a very quick response when additional pain relief was requested.
- There was a policy for the management of pain in the latent phase of labour. This is described as a period of time when there are painful contractions and some cervical change, including cervical effacement and dilatation up to 4 cm. This included the administration of opioid analgesia.
- Women could hire transcutaneous electrical nerve stimulation (TENS) machines from the New Forest Birth Centre. However, if they wished to use TENS machines in the Princess Anne Hospital, they were required to bring in their own. The service did not provide any complementary therapies for pain relief other than the use of birth pools.
- PCA was available in the Princess Anne Hospital. The delivery suite had two pumps which delivered the drugs. Midwives told us it was rare for more than this to be requested.
- Women were able to have epidural analgesia on the delivery suite. This option would not be not available in the midwife led units and information about this was provided to women when they chose their place of birth.
- When a women requested an epidural, staff aimed to have this in place within one hour. Failure to meet that target was incident reported and reasons for delay investigated. The presence of a dedicated anaesthetist on the delivery suite ensured delay rarely occurred. Figures supplied by the trust indicated that 41.2% of women having their first baby (higher than the national average of 34.9%) and 11.8% of women having second and subsequent babies (slightly less than the national average of 12.1%) had an epidural.
- Midwives described the new electronic medicines system as a problem on the delivery suite. In order to administer medication, women were required to be processed onto the electronic system. This meant there was a potential delay if a woman arrived in advanced labour and requested immediate pain relief.

Nutrition and hydration

- Patients' on Bramshaw Ward had their nutritional status assessed using the Malnutrition Universal Screening Tool (MUST) and referrals were made for dietician support as needed. Nutritional screening was not undertaken within the maternity service. Meal times on Bramshaw Ward were 'protected' in order to ensure patients were free to eat their meals. There was a red tray system in operation, which highlighted which patients required support and monitoring with their meals.
- There was a small hyperemesis unit for the management of women with severe hyperemesis (vomiting in pregnancy). This consisted of two relaxing chairs where women could attend as day case patients to receive intravenous fluid rehydration treatment. This prevented the admission of these women.
- Women were encouraged to remain hydrated in labour.

- The maternity unit employed infant feeding specialists and provided breastfeeding clinics and drop-in sessions, Monday–Saturday, 10am to 1pm, to provide ongoing support to women. November's performance dashboard reported 77% of women initiated breastfeeding during quarter 2. This was in line with the England average. Artificial feeds were available to women wishing to bottle feed their babies. The New Forest Birth Centre had a 'milk kitchen' where women were taught to sterilise bottles and safely make up milk feeds. Midwifery managers described a desire to extend this into the Princess Anne Hospital.

Patient outcomes

- Information related to outcomes for patients using the service was collated within performance dashboards for both gynaecology and maternity services. All maternity staff received emails each month detailing the performance dashboard, which were presented at the Women's and Newborn Clinical Governance Committee.
- Gynaecological dashboards indicated performance in line with local and national targets for such activities such as colposcopy referrals, cancer admitted patients, and 18 week referral to treatment targets.
- The maternity performance dashboard for November 2014 showed year to date figures for place of birth: 78.7% of all births occurred in the obstetric-led delivery suite, 13.7% in the Broadlands Birth Centre, 5% in the New Forest Birth Centre, 1% as planned home births, 0.3% as unplanned births, and 1.2% of babies were born before the woman arrived at the hospital.
- Transfer rates from midwife-led care were also reported within the dashboard. There were high rates of women in labour transferred from the Broadlands Birth Centre to the labour ward. A total of 42.3% of women were transferred in labour, with only 4% for maternal reasons following delivery, and 0.7% for care of the newborn baby. However, women were being advised to start labour in the birth centre and then to transfer if and when they decided to transfer.
- A figure of 98.1% of women were booked for antenatal care by 12 weeks and 6 days gestation, which is higher than the national target of 90%. However, there was a requirement for sickle cell and thalassemia screening to be undertaken by 10 weeks gestation. In order to try to address this, midwives were starting to target earlier booking to women who had been identified as higher risk.
- The maternity service employed antenatal screening co-ordinators and contributed to the national antenatal screening programme.
- The number of repeat neonatal blood spot tests were monitored. These had been identified as having increased significantly in July 2014, from 10 to 27. As a result, an awareness campaign had been conducted, including additional education and practitioner follow-up where avoidable repeats occurred.
- There was a detailed audit cycle including local and national audits, which included decision to delivery times for emergency caesarean sections and epidural rates.
- The National Neonatal Audit Programme (NNAP) 2013 reported 82% of mothers, who deliver babies between 24 and 36 weeks gestation, were given any dose of antenatal steroids; this was below the NNAP standard.
- The maternity service contributed to national research programmes, including NIPT (non-invasive prenatal testing).
- The maternity unit had not been accredited for UNICEF Baby Friendly status. This is not a compulsory accreditation and when discussed, midwifery managers described this as a conscious decision.

Competent staff

- All the patients we spoke with on Bramshaw Ward regarded the staff as "very good" and they felt they had the necessary skills to deliver their care. A patient told us "the staff seem to know what they are doing". A patient said staff were "brilliant and explained everything very well and make you feel relaxed".
- Nursing staff on Bramshaw Ward had not received any dementia training; they felt this would be helpful to them.
- The colposcopists received accreditation every three years with the BSCCP (British Society for Colposcopy and Cervical Pathology). Follow-up of histology occurred as a means of auditing own practice.
- Newly qualified midwives referred to a "very good" preceptorship programme lasting one year. All recently qualified midwives we spoke with told us they had felt supported during this period. New midwives were given a day a month where they were not counted in the required numbers of midwives. This enabled them to carry out any required learning. Newly qualified midwives all gained experience on the delivery suite prior to rotating into the community. This ensured they

had the skills and competence if required to work on the delivery suite at a later date. We were told staff on the delivery suite were "proactive at getting you to a band 6 (through the preceptorship period)". The skills in which midwives were yet to become competent were marked on the handover board on the delivery suite, in order that opportunities for them to be supervised and then signed off as competent were not missed.

- Midwives and obstetricians undertook annual skills drills training in obstetric emergencies, such as post-partum haemorrhages and the management of shoulder dystocia.
- We heard from managers that more junior staff were given positive feedback in writing, so that they could add this to their appraisal file. Midwives told us this happened in practice and it helped them feel valued.
- Additional skills and education could be obtained, although it was recognised that funding would not always be available. Staff were given time to attend courses on the proviso that the subject was of relevance to the service and their role.
- All midwives and students were assigned a supervisor of midwives (SoM). A SoM is a midwife who has been qualified for at least three years, and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council (NMC) 2012). They are someone to whom midwives go for advice, guidance and support, and they monitor care by meeting with each midwife annually (rule 9, NMC, 2012). Other roles include auditing the midwives' record keeping and investigating any reports of problems or concerns in practice. All midwives we spoke with had received an annual supervisory review. The trust midwife to supervisor ratio was 1:15, which equalled the recommended ratio of supervisors of midwives. There were midwives in training to become supervisors as part of succession planning.
- Some maternity support workers were trained to undertake venepuncture, and some midwives were trained in basic ultrasound techniques and growth scans.
- Junior doctors reported feeling well supported throughout their placement. Access to education was good. The anaesthetic department underwent a routine deanery review in November 2014. Feedback indicated exceptional multidisciplinary approaches and team working, with three ward rounds daily on the delivery suite involving obstetric consultants, trainees and midwives, as well as anaesthetics consultants and trainees.

Multidisciplinary working

- Staff told us there was good multidisciplinary working and "very good" support from doctors of all specialities.
- Nursing staff on-call for maternity theatres helped out on Bramshaw Ward if they were short of nurses at night. Similarly, nursing staff from Brook Ward (a trauma and orthopaedic ward located within the hospital) would help on Bramshaw Ward if needed. One consultant described theatre staff and nursing staff on Bramshaw Ward as "excellent and much better than other hospitals", with good communication between disciplines making delivery of care "run smoothly".
- There were good working relationships with the gynaecological oncology nurses. Referrals were made from clinics, which meant the patients were known to them in advance of admission unless the diagnosis was made during surgery. Where this occurred, patients were referred to the oncology team within 24-48 hours.
- Theatre staff were provided and managed by the surgical services division. There was good communication and team working to ensure adequate theatre and recovery care was provided at all times. At quieter times, delivery suite midwives provided additional support to women in the recovery area.
- We heard from a range of staff about the existence of a strong, mutual respect and team working between midwives and doctors. One midwife said, "the doctors take on board that we are the women's advocate and they listen to us".
- Staff we spoke with described good working relationships with the staff from the neonatal unit. The transfer of babies from maternity into the unit was described as occurring "very smoothly". Transitional care was provided on the postnatal wards by nursery nurses, with outreach support easily accessible from the neonatal unit.
- There was an obstetric physiotherapist whom one midwife described as "very accessible". They carried out their own daily ward rounds, but we were told that midwives could make direct referrals to them, such as for women with bladder incontinence or a third degree tear.

- Midwives referred women directly to consultant advice. In addition, advice could be sought via email, with consultants providing a quick response to midwives concerns.
- Ward rounds and safety briefings were multidisciplinary, promoting effective communication and shared decision-making. There was a close working relationship with consultants from other specialities, particularly anaesthetists, cardiologists and diabetologists, who held joint clinics with obstetricians.
- There was cohesive working with outside agencies, such as social services to promote the safeguarding of mothers and babies, and with the ambulance services.

Seven-day services

- The EPU (early pregnancy unit) was only open Mondays to Fridays. At weekends, any women requiring a scan who was not presenting as a clinical emergency, was required to wait until Monday.
- The maternity day assessment unit was open seven days a week, from 9am until 2:30am. This had previously been open 24 hours a day, but opening times had changed following a review of throughput. Outside of these times, women requiring assessment were seen on the delivery suite.
- Midwives had access to a mobile phone number in order to contact the obstetric physiotherapist at weekends.
- Consultants were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors.
- There was access to an on-call pharmacist outside of usual pharmacy opening hours, and to provide 24 hour support with the electronic prescribing system.
- Complex scans were only available Monday-Friday; however, scans could be undertaken to identify the fetal presentation and placental location, on the delivery suite at all times.

Access to information

- Staff had access to medical records. On booking, medical records were obtained for use during the pregnancy. Staff reported good access to records within the gynaecological service.
- Women carried their own pregnancy records, which were used by all clinicians they had contact with during their pregnancy. When women moved onto the postnatal wards following the birth of their baby, new records were made for use in the postnatal stage, which included all information relating to the pregnancy and delivery, as well as information on the baby. These were then used by the midwifery and medical teams to record care.
- Medical records were created for each baby at birth.
- We observed staff using the SBAR (situation, background, assessment and recommendation) communication tool when handing over from one to another, to ensure effective communication occurred.
- Staff had access to up-to-date policies and guidelines on the trust's intranet site. They also received performance data and updates via email. These were also produced in paper format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- On Bramshaw Ward there was a pathway identified to ensure the correct procedure was followed when considering and applying for someone's liberty to be restricted. One nursing sister had followed the process recently and reported that a multidisciplinary meeting, including the patient and a relative, had been quickly arranged. This nurse said the trust's DoLS Safeguarding matron had been easily accessible for advice.
- Records reviewed showed discussions with women, and verbal consent was obtained prior to procedures, such as internal examinations and the management of the third stage of labour.
- We saw the reasons for procedures were documented, and consent forms completed and signed by women prior to surgical interventions. These were stored securely within the hospital notes.
- Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. During the inspection there were no patients subject to a Deprivation of Liberty application. Information about MCA was displayed on Bramshaw Ward.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Care was seen to be delivered with kindness and compassion. Women were involved in decision-making and staff ensured understanding and involvement of patients and their partners/relatives, and emotional support through good communication. The CQC Survey of Women's Experiences of Maternity Services 2013, and also responses to the Friends and Family Test, showed the trust to be performing about the same as other trusts. Women told us they felt able to cope if outcomes were different to what they had expected. There was midwife support if a women was transferred to hospital from home or from the New Forest Birth Centre; and the need for end of life care was recognised, and there was good palliative care support.

Compassionate care

- We saw staff treat women with kindness and compassion. We received positive feedback from patients and their relatives about the caring and compassionate approach of staff. Comments from patients included "excellent care". Another patient said "the staff explained everything very clearly".
- Patients told us they were treated with respect and dignity, and had their privacy needs considered, such as using modesty sheets when patients were being examined.
- On Bramshaw Ward, partners were made to feel welcome and were able to stay with women whilst they were undergoing medical termination of pregnancy on Bramshaw Ward. The women were allocated with one to one staff to provide care and emotional support.
- One woman described the reassurance she received from the continual presence of a midwife. She described feeling very anxious which eased due to the continued presence of the midwife.
- The service participated in the NHS Friends and Family Test. Response rates were in line or higher than the national average. The performance dashboard for gynaecological services indicated 98% of patients were satisfied with the care they had received. Results for the maternity service for December showed 73.8% of women were extremely likely to recommend the service, whilst 98% were likely to overall.
- The CQC Survey of Women's Experiences of Maternity Services 2013 showed the trust to be performing about the same as other trusts for all questions, and better than other trusts for the question 'were you and/or your partner or companion left alone by midwives or doctors at a time when it worried you?'

Understanding and involvement of patients and those close to them

- Patients reported "excellent" communication from doctors and nurses in explaining procedures and involvement in decision-making. Our observations at two different gynaecology clinics showed women were involved in their care, decision-making and treatment.
- We observed one member of staff provide reassurance regarding the noise from equipment. Later this patient told us this made her "feel at ease". On another occasion we witnessed one midwife showing a father how to dress his newborn baby. The father was encouraged to overcome his nervousness and become involved in the baby's care.

Emotional support

- All the patients we spoke with, either women in the maternity service or patients on Bramshaw Ward, agreed that staff had explained what was happening as events unfolded. This, along with presenting the options and choices available, had helped them cope when outcomes were different to those they had expected.
- Nursing staff on Bramshaw Ward had not received any training in palliative care or bereavement. Patients with breast and gynaecological cancers were treated there; however, staff told us it was rare for a patient to be on the ward for end of life care. End of life was recognised as being within the last 12 months of life, and staff described good support and access from the trust's palliative care nurses. There was an end of life link nurse on the ward who had quarterly meetings with all the other link nurses to keep up to date with the best practice.
- Women transferred into the delivery suite from home or from the New Forest Birth Centre were accompanied by

the midwife who had been providing their care. They would then remain with the woman to provide continuity of care. One woman told us "the midwife managed the situation really well; they were a calming influence".

- The maternity service employed a bereavement specialist midwife and a perinatal mental health midwife to provide advice and support to women, but also to midwives to build their skills and confidence.

Are maternity and gynaecology services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

Women were able to make choices on where to have their babies, with the choice of home, midwife-led care in a free standing birth centre, midwife-led care in an alongside birth centre, or obstetric-led care. Women were also able to receive ante and postnatal care and support in the New Forest Birth Centre. Multidisciplinary clinics were held for women with complex care needs.

The provision of gynaecological care occurred within the 18 week referral to treatment (RTT) target timeframe. Theatre slots were filled based on the needs of women, and regular theatre slots were allocated to the early pregnancy assessment centre to facilitate surgery within 24-48 hours if required.

One ambulance was on stand-by at the Princess Anne Hospital site for routine transfers. An emergency ambulance from the local ambulance service had to be called for any sicker women or babies to be transferred to the main site. In order to prevent delays, the trust had met with the ambulance service and agreed a procedure to remove the need for routine triage questions, and for the most appropriate staff to accompany the patient.

In places, bed spaces were small and over cramped as a result of the hospital being built to provide a maternity service to only 4,000 women. Women undergoing induction of labour were cared for in a very small room with no windows and little room for privacy. Curtains remained pulled at all times, and bed spaces were such that women and their partners were unable to walk around their bed without dislodging the curtain. The trust were discussing options such as, 'Outpatient Induction' to improve the patient experience and relieve the pressure within the area.

There was only one dedicated obstetric theatre open from 1.30pm to 5.30pm. But since opening a second obstetric theatre every morning, the percentage of women waiting more than three hours for suturing in theatre had reduced from 62% to 22%.

Translation services were available. Staff were able to access support for patients with additional needs, such as learning disabilities and women requiring additional support.

Women had access to information to support their diagnosis or pregnancy options. Some information was available in different languages. Complaints were dealt with proactively, and in line with the organisations policy. Senior staff visited ward areas daily with the aim of addressing any concerns as they arose.

Service planning and delivery to meet the needs of local people

- The maternity services were designed and built to accommodate 4,000 births per year. As a result of an increased birth-rate, some rooms and areas felt very cramped. For example, the room used to conduct inductions of labour was very small. It had no window and in order to provide some privacy, curtains were drawn around each of the four beds. Bed space was such that women and their partners were unable to walk around their bed without dislodging the curtain. Midwives told us they found this area to be very cramped and one described it as 'embarrassing', whist a senior manager told us they believed it was "unfit for purpose". Staff felt the organisation had a desire to improve facilities, but lacked the funds to allow this to happen. The trust was discussing options such as, 'Outpatient Induction' to improve the patient experience and relieve the pressure within the area.
- Due to a peak of births booked for December 2014 and early January 2015, the service maintained safe staffing levels by closing the New Forest Birth Centre on three days. This meant women were not always able to give birth in their location of choice, although they were able to give birth at Broadlands Birth Centre instead.

Maternity and gynaecology

- Monitoring of bookings allowed the maternity service to identify peaks in activity. In October 2014, staff identified a predicted peak in activity in January 2015; with 565 anticipated deliveries (figures for September were 508, October 488 and November 474). As a result, a paper was presented to the divisional board in November requesting additional staff, rescheduling of planned training, and the release of specialist midwives for some of their time back into clinical practice. This was approved by the divisional board.
- Most routine antenatal care was carried out by community-based midwives. Antenatal clinics were held at the Princess Anne Hospital from Monday to Friday. In addition, outreach clinics were held at the New Forest Birth Centre; for example, women described attending to have glucose tolerance tests taken. Access and parking was good, and they were able to sit and relax in the day room whilst undergoing tests.
- Multidisciplinary clinics ran for women with complex needs. In addition, fetal medicine clinics were held. There were other clinics available at the New Forest Birth Centre, such as one half day clinic a week for babies with tongue tie, a half a day a week clinic where women could have an anti-D immunoglobulin injection, and twice weekly clinics for the newborn's initial physical examination. This meant local women could access services in a location other than the hospital in the city, or closer to their home.
- There was only one dedicated obstetric theatre opened from 1.30pm to 5.30pm. At all other times one theatre was immediately available for emergencies and a second team available to be called upon if the second theatre was needed. More pressing emergencies were prioritised into the one theatre immediately available. Access was delayed for non-emergency procedures, such as the repair of third and fourth degree perineal tears. Since opening a second obstetric theatre every morning, the percentage of women waiting more than three hours for suturing in theatre had reduced from 62% to 22%.
- The New Forest Birth Centre was also open for postnatal checks at the weekend, which gave women the option of attending an appointment rather than waiting at home for the midwife to visit.
- Early booking ensured women had access to antenatal screening. The trust target was to have 90% of women booked for antenatal care by the time they were 12 weeks and six days pregnant. Data for quarter three showed this had been achieved for 98.1%.
- The number of women delivering in the birth centres or at home had declined over the last four years. Staff did not know why this had occurred.
- Despite having medical and surgical outliers on Bramshaw Ward, staff said they did not have to cancel booked patients because of a lack of beds. Referral to treatment times were within the 18 week target. The service also ran 'one stop' post-menopausal bleed clinics, and an outpatient hysteroscopy service.

Access and flow

- The Princess Anne Hospital was five minutes' walk from the main hospital and across a main road. Being a separate building was recognised as a risk on the division's risk register in terms of financial risk, patient experience and safety . Gynaecological patients who were identified as likely to need intensive care post-operatively were admitted to the main hospital for surgery.
- Bramshaw Ward was in the process of developing a nurse-led discharge initiative. The policy contained clear guidance on exclusion and inclusion criterion. Training and competency framework were included for band 6 and 7 nurses, who would have responsibility for this service.
- There was one ambulance on stand-by at the Princess Anne Hospital site for routine neonatal transfers. An emergency ambulance from the local ambulance service had to be called for any sicker women or babies to be transferred to the main site. This could cause delays. The trust had met with the ambulance service, and there was an agreed procedure to remove the need for routine triage questions, and for the most appropriate staff to accompany the patient. This was to reduce delays as far as possible.
- Patients attending gynaecology clinics on H level told us they often had an average of 45 minutes wait to be seen. It was unclear why there was this delay.
- Flow through the antenatal day assessment unit was supported by some staff undertaking extended roles; for

example, maternity support workers were trained to undertake venepuncture, and some midwives were trained in basic ultrasound techniques and growth scans.

- Peaks in activity were identified around lunchtime and after 6pm in the maternity day assessment unit, with no doctor specifically allocated to work there. This left women waiting in a small area to be seen by the doctor. A midwifery sister had raised this with the medical director and it had been suggested that 'extended pathways' could be introduced. This would mean some women in the unit being further assessed by midwives rather than doctors. A working party had been set up to discuss the idea. Staff reported the area to be small, with insufficient beds to meet demand. Women were required to wait in a small waiting room at the entrance to the delivery suite at times, until a bed was available.
- The early pregnancy assessment clinic had two theatre slots allocated on Mondays and Thursdays if required. This meant women requiring surgical evacuation of retained products of conception could have surgery within 24-48 hours of presentation.
- Patients for medical termination had open access, and contact details for help and support. Beds were reserved for admission up to 48 hours, or earlier as needed. Staff on Bramshaw Ward had raised money through sponsorship to refurbish a room to a high standard.
- Discharge information was communicated to GPs and midwives when women were discharged from either of the services. Discharge summaries were written and sent to the GP to ensure they were aware of the care and treatment undertaken.
- Access to parking and car parking costs were recurrent concerns shared with us by patients and their relatives.

Meeting people's individual needs

- The trust provided women with a booklet entitled Choosing where to have your baby. In line with NICE guidelines, the trust offered care in four settings. This included their own home, the freestanding New Forest Birth Centre, the midwife-led co-located Broadlands Birth Centre within the Princess Anne Hospital, and the obstetric-led delivery suite. The booklet gave information in a factual, non-persuasive way, so that women could make an informed choice. The preferred place of birth was discussed with all women on booking with the community midwife and reviewed throughout the pregnancy.
- There was good access to information for women. The trust had an informative website which contained hyperlinks to information leaflets and provided information on each unit. In addition, visitors to the site could undertake a virtual tour. Some information leaflets were available in different languages. These were given at booking to explain choices to women. Information leaflets were also available to women receiving gynaecological care.
- Women were fully involved in decisions regarding place of birth. Options were discussed at booking and this was supported with information leaflets, meaning women had information to take away and discuss with their partners.
- As early as possible in pregnancy, women were invited to a parent information evening. This offered advice and information to expectant parents and those planning to be pregnant, regarding all aspects of pregnancy, such as diet, breastfeeding, nappies, car seats, and travelling abroad.
- If required, staff had access to support from the learning disability nurse specialist team who were located in the main hospital.
- Caseload midwives provided greater continuity of care to the women on their caseloads. They worked out of areas of greater deprivation. Specialist midwives in drug and alcohol misuse, and perinatal mental health, were employed to provide support to women and their partners, and also to the midwives providing care.
- Medical terminations were carried out on the delivery suite. Women were given the choice for place of delivery with staff from both the maternity unit and Bramshaw Ward supporting, in order to provide the best support to the woman. There was good chaplaincy support available as needed.
- Women undergoing medical termination of pregnancy were nursed in a side room, with additional facilities such as a fridge and hot drinks making facilities. Partners were welcome and supported to remain with the woman.
- At times, Bramshaw Ward had male inpatients. Men undergoing treatment for breast cancer underwent surgery there. To protect the privacy and dignity of all patients on the ward, men were only admitted

post-surgery and were allocated a side-room with ensuite facilities. Occasionally men were admitted to a male bay with facilities across the corridor. The trust had not identified any mixed sex breaches on the ward. .
- One room on the delivery suite was used as a bereavement room. This had also undergone a refurbishment.
- Translation and interpretation services were available through a telephone system. Staff were aware how to access this if required. Some information leaflets were available in other languages.
- Patients and relatives told us there were no facilities to make drinks or have snacks on wards. Vending machines existed on the ground floor, but this meant leaving the ward to access them.
- Patients were offered a choice of meals. The menu was varied and also available in a pictorial format. Specialist meals were available, such as halal and vegetarian. We received mixed feedback regarding the food provided. Most patients were satisfied with the meals, and said they were provided in sufficient amounts and meals were served hot. However, this was not universal, with some patients describing food as "tasteless". The 2013 PLACE inspection for food and hydration rated the service at 89.1%, worse than the England average, which was 93.3%.
- Photographs, certificates, cards and other items, such as hand and foot casts, were provided to bereaved parents.
- There was no provision for partners to remain overnight with women unless they were actively in labour on the delivery suite. This included the New Forest Birth Centre.

Learning from complaints and concerns

- Patients and their partners were encouraged to provide feedback on their experiences. Information was available in clinical areas on how they could raise a concern or make a complaint.
- Complaints were discussed at trust level, and feedback was given at staff or handover meetings. Lessons learnt were also contained in newsletters and themes of the week.
- On Bramshaw Ward senior nursing staff carried out a daily walk around. During this, patients were asked about any concerns they may have. This meant any issues raised could be addressed promptly and prior to discharge.
- The maternity service had made a bid for additional funding, to be able to purchase electronic CTG storage. This was in recognition that the ability to read paper traces deteriorated with time, which could have an impact on the ability to respond to older complaints made about care during labour.

Are maternity and gynaecology services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

The maternity service was in the process of developing a new vision and strategy, which would involve changes to the way midwives worked to deliver care. The approach would mean staff were moved around the service less but would enhance the continuity of care. This had involved staff surveys and a listening event, with a plan to fully involve staff and service users in the onward development.

The service had a well-defined governance structure, with a good connection to the board. Activity, quality and risk were monitored and reported on. The service was aware of its risks and was taking action,. Specialist midwives and administration staff were employed to support the governance function.

Staff were positive about the support from the senior staff and immediate managers, and there were plans to support succession planning. Staff described an open culture, which encouraged honesty, and were able to describe changes in practice as a result of this. Success was praised. Not all staff, however, felt a strong connection with the main trust.

There was good patient and public engagement, with a 'birth afterthoughts' service enabling women to have a debrief with a midwife following delivery. In addition, a maternity patient group met quarterly, reviewing documents and providing comment on the vision of the service. Views were generally sought from women at all

stages, and the birth centre had a Facebook page to promote and publicise the service. Women were encouraged to report their experiences of the maternity services via an online feedback portal.

The maternity and gynaecological services were implementing a number of new innovations. The maternity service had worked with local universities to develop changes to the midwifery course, to establish two cohort intakes per year from February 2016, in order to provide a steadier stream of new midwifery staffing to the service. A telephone triage service with a neighbouring trust had been agreed and was about to be implemented. This initiative would direct women to the appropriate place for care. Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration; seen as innovative practice, this meant they could remain at home and helped to prevent admission.

Vision and strategy for this service

- The maternity services were in the process of developing a new vision and strategy, which would involve changes to the way midwives worked to deliver care. The strategy was one of integrated midwifery, with the aim of having midwives follow women through the service. A listening event for all staff employed by the maternity service had occurred, and staff had been surveyed on what they felt worked well and less well. Findings had been presented to staff groups. The service was planning a full day in February 2015, bringing together 30 staff from a variety of roles to develop the strategy and ideas for the future.
- Staff were less clear on the vision within the gynaecological services. The service did not have a strategy and some staff describing the service they worked in as “just treading water”.

Governance, risk management and quality measurement

- The maternity and gynaecological service had a well-defined governance structure. Service-wide meetings were held which oversaw activity, performance, quality, safety, audit and risk. Specialist midwives and administration staff were employed to support the governance function of the service.
- Gynaecological governance meetings were held, and both services reported into the women’s and newborn clinical governance group. This reported to the trust clinical governance group. Both the maternity and gynaecological services produced performance dashboards. These were presented every month to the care group clinical governance meeting, and quarterly to the board.
- In addition to the formal meeting minutes, the head of midwifery held weekly quality meetings and weekly breakfast meetings with senior midwives. These were used to share information and to provide senior staff with support. During these meetings, senior staff also discussed activity and progress, or blocks with different work streams. The head of midwifery told us how these ensured she was always kept up to date.
- There was a service-wide risk register. The highest risk identified related to capacity other high risks included staffing and medical equipment . Staff told us they would escalate risks identified to their managers for inclusion in the risk register. The anticipated increase in workload in January 2015 had been identified on the risk register and actions put in place to mitigate the risk.
- Audit programmes were actively monitored, and patient outcomes recorded and reported nationally. Outcomes were reviewed at audit meetings, and actions monitored and re-auditing planned.

Leadership of service

- Staff were positive about the support from the senior staff and immediate managers.
- Doctors told us there was “very good leadership”. They said the consultants were “very supportive” and they worked well together.
- Senior nursing and midwifery staff were described as visible and approachable. The head of midwifery was described by one midwife as “passionate and always there for the staff”.
- Senior midwifery management were aware that some of the senior management team were nearing retirement age. The service had a plan to ‘grow their own’ managers. This included providing band 6 academic and practical development opportunities. This had currently been undertaken by five staff. There was also an ‘in house’ band 7 leadership course, entitled ‘good to great’, which staff had been supported to complete. There had also been agreement to have an overlap of roles before one of the existing matrons retired.

Culture within the service

- Staff described an open culture, which encouraged honesty, and were able to describe changes in practice as a result of this. One midwife told us they were "confident action would be taken straight away if I was concerned about someone's professional practice. That goes for any level of staff I might report it to". Staff were aware of the whistleblowing policy and felt concerns would be listened to.
- Successes were praised. Midwives told us they appreciated when midwifery sisters, managers and matrons told them when women had mentioned them personally in NHS Friends and Family Test questionnaires.
- Some integrated midwives reported feeling daunted and, at times, intimidated to work in an area they were unfamiliar with. This was felt particularly when all other staff were core staff members.
- Staff did not feel a great connection with the main trust, although all spoke highly of the chief executive's weekly blog.

Public and staff engagement

- There was a 'birth afterthoughts' service, which enabled women to have a debrief with a midwife following their delivery. Themes from this service were identified and fed into the governance process. Over 400 women had accessed the service during 2014.
- There was a maternity patient group that met quarterly. They were involved in reviewing documents and providing comment on the vision of the service.
- There were plans to involve the patient group to develop a maternity vision and strategy. In addition to a patient group, a mother provided patient representation on the intrapartum care group.
- There were two Maternity Service Liaison Committee (MSLC) groups pertinent to Southampton, Hampshire MSLC and Southampton City MSLC. The purpose of these was to contribute to the improvement of maternity care and facilities for parents and babies.
- The New Forest Birth Centre had a Facebook page, where staff posted updates and discussions could occur.
- Views were generally sought from women at all stages. As well as views from the Friends and Family Test, women were encouraged to report their experiences of the maternity services via an online feedback portal. However, despite generally involving women in changes and developments, women's views not been sought regarding changes to the newborn screening process.

Innovation, improvement and sustainability

- The maternity service had worked with local universities to develop changes to the midwifery course. This was to establish two cohort intakes per year from February 2016, instead of one. Two cohorts would result in the ability to recruit newly qualified midwives twice a year instead of once. It was felt this would help to provide a steadier stream of new midwifery staffing to the service.
- It had been identified that many women with concerns phoned the Broadlands Birth Centre. The centre received approximately 75 calls per day, taking midwifery and support staff away from providing direct patient care. As a result, the development of a 'Labour line' with a neighbouring trust had been agreed. This initiative would act as a telephone triage service, with the aim to then direct women to the appropriate place for care. Staff for this were currently being advertised.
- Senior midwifery staff were aware of the need to build greater continuity of work areas for midwives. This would mean less movement on a daily basis for midwives. This was one of the aims of the remodelling exercise which was currently underway.
- Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration. Seen as innovative practice, this meant they could remain at home, and helped to prevent admission.

Outstanding practice and areas for improvement

Outstanding practice

- Midwives who held a caseload (caseload midwives) worked in areas of greatest deprivation and with the largest number of teenage pregnancies. These midwives had smaller caseloads and provided greater continuity of care, and often followed the women into the maternity unit to deliver.
- There was a 'birth afterthoughts' service, which enabled women to have a debrief with a midwife following their delivery. Themes from this service were identified and fed into the governance process. Over 400 women had accessed the service during 2014.
- Women with hyperemesis could be cared for as day case patients and receive intravenous fluid rehydration. This meant they could remain at home, and helped to prevent admission.
- A telephone triage service with a neighbouring trust had been agreed and was about to be implemented. This initiative would direct women to the appropriate place for care.

Areas for improvement

Action the hospital MUST take to improve

The hospital must ensure :

- Operating tables can be lowered adequately, so surgeons are not required to stand on stools, increasing the risk of back injuries to the surgeon and patient risks during surgery
- Ensure all staff are aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools.

Action the hospital SHOULD take to improve

The hospital should:

- Review acuity and midwifery staffing levels to ensure adequate care in all sectors of the service at all times.
- Review consultant cover on the delivery suite in line with RCOG, Safer Childbirth (2007).
- Review the times of provision of a dedicated second obstetric theatre, extending availability to further reduce delay in non-urgent procedures.
- Review systems to ensure that all babies receive newborn examination checks in the appropriate time frame.
- Ensure that action is taken to improve temperature control in rooms in maternity services which are cold at times, with poorly fitted and single glazed windows which make them draughty.
- Ensure staff are aware of how the new call bell system works and, that there are sufficient call bell panels so staff can quickly ascertain location of any emergencies.
- Review the facilities for the induction of labour, to ensure there is sufficient space and capacity to provide adequate privacy and dignity, and to meet demand and reduce waiting times for women.
- Review the provision of facilities for women and their partners to make drinks or have snacks on wards without the need to leave the wards to access vending machines.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.** The registered person did not have suitable arrangements to protect patients and staff against the risk of unsafe equipment by ensuring equipment was properly maintained and suitable for purpose and used correctly. · One operating table could not be lowered adequately, so surgeons were required to stand on stools which increased the risk of back injuries and also increased the risk of harm to patients. · Not all staff were aware of the location or correct use of equipment for the safe evacuation of women from the birthing pools. Regulation 16 (1) (a) (b)(Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.