Portsmouth Hospitals University NHS Trust

Queen Alexandra Hospital

Inspection report

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Date of inspection visit: 24 and 25 October 2023
Date of publication: 09/02/2024

Ratings

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

Our findings

Overall summary of services at Queen Alexandra Hospital

Good ➔➔

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Queen Alexandra Hospital.

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

The Queen Alexandra Hospital provides maternity services to the population of Portsmouth and surrounding areas.

Maternity services include an outpatient department, maternity day assessment unit, maternity triage, antenatal ward, labour ward, midwifery led birthing centre, two maternity theatres, postnatal ward, assessment observation unit, and ultrasound department. Between October 2022 and September 2023 4,874 babies were born at Queen Alexandra Hospital.

We will publish a report of our overall findings when we have completed the national inspection programme.

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

Our rating of this hospital stayed the same. We rated it as Good because:

- Our rating of Good for maternity services did not change ratings for the hospital overall. We rated safe as Good and well-led as Good.

We also inspected 2 other maternity services run by Portsmouth Hospitals University NHS Trust. Our reports are here:

Gosport War Memorial Hospital – https://www.cqc.org.uk/location/RHU10

St Mary's Hospital - https://www.cqc.org.uk/location/RHU02

How we carried out the inspection

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

We visited the maternity day assessment unit, maternity triage, antenatal clinic, labour ward, birth centres, induction bay, maternity theatres, the antenatal and postnatal wards.

We spoke with 47 multidisciplinary staff, 3 women and birthing people and 1 birthing partner. We received 34 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 10 patient care records, 8 observation and escalation charts and 10 medicines records.

Our findings

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

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

Maternity

Good ↑

Our rating of this service improved. We rated it as good because:

- Since the last inspection, there has been improvements such as the training for staff on the use of the birth pool hoist, the storage of patient records, the day assessment unit environment, information governance and data collection.
- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service-controlled infection risk well. The environment was suitable and fit for purpose.
- The service had enough medical staff, planned and actual staffing numbers were equal to each other.
- Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities. Staff spoke positively about the safety culture, collaborative working, and this was reflected in the low turnover of staff and student midwives being satisfied with their experience at this hospital.
- The service engaged well with women, birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- While midwifery staffing levels were improving they did not always match the planned numbers putting the safety of women, birthing people and babies at risk.
- Staff did not always complete the hourly fresh eyes and fresh ears assessments to maintain the safety of women, birthing people and babies.
- In the postpartum haemorrhage audit, the service performed significantly below the expected targets on some of the standards audited.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as Good.

Mandatory training

Maternity

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

Staff were up to date with their mandatory training. Records showed that 79% of clinical staff had completed all required mandatory training courses against a trust target of 85% as of October 2023. Following inspection, the trust told us of the impact the period of industrial action had on training compliance, and that an action plan, and trajectories were in place to increase compliance.

Managers gave staff time away from clinical duties to complete the multi-professional simulated obstetric emergency training (PROMPT). Staff were automatically rostered well in advance to attend training within their contracted hours. As of 25 October 2023, 71% of clinical staff had completed the PROMPT training. Records showed that junior doctors achieved 53% compliance, maternity support workers achieved 75% compliance, consultants achieved 79% compliance and midwives achieved 89% compliance.

Seventy-eight per cent of clinical staff had completed cardiotocograph training and 93% of midwives had completed the required overall medicines management training via the mandatory training and annual maternity trust update.

In the same period, 75% of midwives had completed the perineal suturing training. Ninety-three per cent of midwives and 68% of maternity support workers had completed the required maternity trust update training. Ninety-five percent of midwives had completed the pressure ulcer prevention training and 84% had completed the resuscitation training against the trust target of 85%. Following this inspection as part of the factual accuracy process, the trust advised that 94% of maternity support workers had completed the required maternity trust update training.

Across the trust 3 maternity services, as of 25 October 2023, 93% of midwives and 68% of maternity support workers had completed the yearly training in pool cleaning, waterbirth, pool evacuation and hoist.

We raised our concerns with senior managers around the low compliance on the completion of staff mandatory training. Following the inspection, the trust told us about the low compliance by the maternity support workers was because 20 of the maternity support workers were new recruits that had recently commenced in post and were still in their induction period. The recent industrial action had affected the junior doctors training by 13% and the trajectory showed compliance for PROMPT and fetal monitoring would be between 80% to 90% by end of December 2023. The trust provided us revised data, which excluded newly recruited staff. The revised data showed that 89% of midwives and 85% of maternity support workers had completed the PROMPT training. The revised data showed that 81% of the maternity support workers had completed their maternity trust update and the pool cleaning, water birth, pool evacuation and hoist training. The trust advised that all the staff would be compliant with their training by 15 December 2023. Following this inspection as part of the factual accuracy process, the trust provided evidence which demonstrated improvement in staff training compliance. As of January 2024, 87% of clinical staff had completed the PROMPT training. Records showed that midwives achieved 99% compliance, maternity support workers achieved 96% compliance, consultants achieved 84% compliance and junior doctors achieved 79% compliance, Data showed that 93% of clinical staff had now completed their cardiotocograph training. Also, the maternity support workers compliance had improved to 94% in the pool cleaning, water birth, pool evacuation and hoist training.

Clinical staff confirmed they completed training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. Data showed that compliance for the perinatal mental health training was 93% for the midwives and 81% for the maternity support workers as of 25 October 2023. As of September 2023, 99% of midwifery staff had completed the dementia training and 80% had completed the deprivation of liberty safeguards training against a trust target of 85%.

Staff completed regular skills and drills training. For example, staff had recently completed pool evacuation skills and drills.

Senior staff told us there were challenges in the medical staff completion of mandatory training and the service was looking at implementing a digital staff training passport system. The digital staff passport will enable junior doctors to hold a verified portfolio of core skill training competencies and can transfer over common mandatory and staff training, without the need to duplicate training.

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

Staff were undertaking training in how to interact appropriately with autistic people and people who had a learning disability which was in accordance with The Health and Care Act 2022. A requirement was introduced which said providers of regulated activities must ensure their staff receive learning disability and autism training appropriate to their role.

Two staff had been funded to complete a midwifery apprenticeship programme at a local university and 3 staff had commenced the inhouse level 3 apprenticeship programme.

Senior managers told us that 8 staff had been funded to attend the MBBRACE UK conference in October 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, and they could also look at the electronic staff record directly so they knew when to renew their training.

Safeguarding

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

Not all staff had received training specific for their role on how to recognise and report abuse at the time of inspection. Safeguarding training was set out in the trust Safeguarding Training Strategy. Midwives had level 3 training, with a full day training every 3 years and refreshers in between. Training records showed that 90% of midwives, 84% of maternity support workers and 66% of consultants had completed the Level 3 safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. This was against a trust target of 85% for all roles. The trust did not provide us with the data for the middle grade and junior doctors and this was not an improvement since the last inspection. Following this inspection as part of the factual accuracy process, the trust provided evidence which showed that consultants had achieved 73% compliance in the level 3 safeguarding children training as of January 2024.

The trust provided a procedural document for safeguarding vulnerable adults, children, and young people. We saw a copy of this and noted it was re-approved in 2022 and was next due to be reviewed in 2025. The content provided information to staff to help them undertake their responsibilities as fully as able, including making a safeguarding referral. The reporting of female genital mutilation was stated as mandatory in the guidelines.

Maternity

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. Safeguarding vulnerable women, birthing people and babies was a key role of staff working in maternity services. Information about safeguarding concerns was identified as part of assessment and the ongoing management and support of individuals. Flags were attached to the electronic patient records, and a separate handover of safeguarding concerns were shared with staff at each shift change. Staff attended several safeguarding meetings such as prebirth planning meetings, strategy meetings and case conferences to ensure women, born and un- born babies, birthing people and their families were safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could contact when they had concerns. The maternity specialist safeguarding midwife was part of the corporate safeguarding team. They dealt with paperwork, undertook a daily ward round, and liaised with community services and local authorities for ongoing support.

Care records detailed where safeguarding concerns had been escalated in line with local procedures. Safeguarding handover documents were started as early as possible in the persons pregnancy, usually from triage. Self-referrals could also be made to the team by women and birthing people.

Staff followed safe procedures for children visiting the ward.

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

Staff had access to regular safeguarding supervision.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, we observed some surface dust on some equipment on the antenatal and post-natal wards and this was brought to the attention of a midwife.

Staff cleaned equipment after contact with women and birthing people. Except for the resuscitaire, "I am clean" labels were not always attached to equipment to show when it was last cleaned on the antenatal and postnatal wards. We checked a range of equipment, including breast pumps, observational items, balance balls and sonicaids and found they were all clean. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

The service generally performed well for cleanliness. From July to October 2023, the cleaning audit result showed 97% compliance.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Check lists were completed for the environment daily and we saw these records. Housekeeping staff worked across the maternity wards and had the right equipment to enable them to meet cleaning standards.

Staff followed infection control principles including the use of personal protective equipment (PPE), bare below elbows, not having wrist-wear items on, false nails or trailing long hair. Leaders completed regular infection prevention and control and hand hygiene audits. Uniforms were visibly clean, and staff used and disposed of personal protective equipment (PPE) correctly. There was good access to PPE in all bed areas and in clinical rooms. Separate clear labelled bins were easily accessible in all areas for the disposal of clinical and non-clinical waste.

Fabric curtains were used around bed areas. Midwifery staff and the infection control team we spoke with confirmed the reason why paper curtains were not used. All curtains were checked daily for any signs of contamination and if noted were reported to housekeeping and changed. At six-monthly intervals or sooner, if required, all curtains were changed. They were laundered on site. They had assessed the risk and deemed there was no greater risk in using fabric curtains.

Data showed hand hygiene audits were completed every month in all maternity areas. Between February 2023 and October 2023 compliance for hand hygiene audits was consistently above 96.4%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment and facilities within the environment. Staff were trained to use them. Staff managed clinical waste well. However, the service did not always have enough suitable equipment on the wards and theatre.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. Air inlets close to bedsides were capped off. Oxygen provision was present, and masks were by each bedside, as was suction equipment.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. Staff had secure access cards. Reminders to staff about the risk of tailgaters gaining access was shared at the morning handover observed.

The service carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas. A ligature risk assessment was last carried out on 3 October 2023.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily.

Maternity

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

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There had been improvement in the decoration and furnishing of the bereavement suite since the last inspection to meet the needs of bereaved women, birthing people and their families. Since the last inspection, the service had made improvement to the environment of the maternity assessment unit, and it was now fit for purpose. The maternity day assessment unit was now co-located within the antenatal clinic area and had adequate number of seats in the waiting area for women, birthing people and families. The triage was in a separate area and had adequate seats in the waiting area. The service had launched an infant feeding room in the beginning of the year on the postnatal ward, which was funded by a charity. The labour ward now had a beverage bay area where women, birthing people and their family could make drinks. This was an improvement from the last inspection.

The service had a lounge room in triage which was used for confidential information and for breaking bad news.

Chairs to enable greater comfort when breast feeding were available on the postnatal ward and there was access to a bariatric chair.

Fridges and a freezer within the milk room were temperature controlled and records showed routine checks were completed and recorded. Equipment for expressing and collecting breast milk was available. Bottled formula was available, and this was stored safely.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

The service had processes to ensure equipment was maintained and tested for electrical safety, demonstrating it was fit for purpose and safe for patient use. Electrical safety checks had been completed on equipment we looked at. However, on the postnatal ward, we were not able to identify if a Bilirubin testing machine and a resuscitaire had been checked as they did not have a test date label, and this was escalated to a staff member.

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

Single use items of equipment were in good supply and stored safely. Our random checks on items showed all but one face mask selected were in date and packaging was intact. Sterile delivery packs were in date and easily accessible on the labour ward and maternity wards.

Assessing and responding to risk

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

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 8 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. The MEOWS had a section for scoring the level of pain too, although on the records we reviewed, we noted this was not always recorded.

Staff completed regular audit of records to check they were fully completed and escalated appropriately. Staff achieved 81% in the vital signs audit against the trust target of 90%.

Women and birthing people had a full assessment of their medical, surgical, psychological, and social history. Risks were identified from this assessment and was used to plan for the right support or treatment. We saw for example, risks related to blood clots (venous thromboembolisms), high body weight, allergies, pre-eclampsia, previous pregnancy difficulties and mental health matters documented on patient records reviewed. Pre-eclampsia is a condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered.

Entries in the electronic patient records (EPR) recorded the actions taken to manage risks. Post delivery risks were identified, such as blood loss and the action taken to address this was recorded. Blood transfusions had been given when required and this was recorded correctly in the records reviewed.

The service carried out a risk assessment audits in September 2023 following 2 external incidents investigation recommendations around risk assessment. The audit result showed 93.3% overall compliance on the 2 standards audited.

The 18 March 2022 World Health Organisation (WHO) surgical checklist audit result showed 95.3% overall compliance.

Staff achieved 94.1% compliance in the VTE assessment audit against the trust 95% target.

The service had implemented a quality improvement project around patient safety and effective communication in triage which was shared with staff and external stakeholders at a learning event. The service had developed a clear escalation guideline which included a maternity trigger list and a clear pathway for staff to follow during high acuity. This guideline was shared with their local maternity network system and the maternity and neonatal safety improvement programme. All the triage rooms had computer on wheels for assessment and equipped with CTG machines to help the timely assessment of fetal monitoring to ensure patient safety.

Women and birthing people had access to the local maternity system healthier together app, which was implemented on 28 November 2022 and used across the SHIP (Southampton, Hampshire, Portsmouth, or the Isle of Wight).

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. Leaders monitored waiting times and made sure women and birthing people could access triage, maternity day assessment unit or the emergency department services when needed and received treatment within agreed timeframes and national targets.

The maternity triage waiting times for review audit for March to September 2023 showed midwives reviewed 77% of women and birthing people within 15 minutes of arrival and 91.3% within 30 minutes of arrival. The audit result showed improvement was needed in the time of doctor review of women and birthing people within the agreed protocol. There

were action plans to improve the doctors review of women and birthing people. Following this inspection, the trust advised during the factual accuracy process that there has been improvement in data input and compliance of triage waiting within 15 minutes. Compliance had improved to 79% against a target of 80% compliance. The service had a quality improvement projects underway to assess the level of activity at various times of the day to help may the midwifery and medical workforce. The service had opened an extra bedspace in maternity assessment unit and developing advanced midwifery practitioner roles to help with the timely assessment and review of women and birthing people. As part of their escalation process, staff could also contact the labour ward and gynaecology team in addition to the on-call consultants 24 hours a day when a medical review was needed.

Triage was staffed with 3 midwives, a receptionist, a senior house officer (SHO), a registrar and a consultant. Medical cover was from 8.15 am to 5 pm and out of these hours, this was covered by the on-call obstetrics and gynaecology team.

The telephone triage line was effective at managing incoming calls, providing advice and liaising with the service to ensure appropriate information was available. The service included a dedicated telephone line outside of the trust, for access to a midwife 24 hours a day, for help and advice and referral to the appropriate maternity service. This had commenced in November 2022 with this trust being part of the LMNS for the design and delivery. Southampton, Hampshire, Isle of Wight, and Portsmouth (SHIP) Maternity Referral is an NHS service providing a single point of access for all maternity referrals in these areas. The aim was to make sure women and birthing people had access to the right care as soon as they contacted the service. SHIP Maternity Referral staff triaged women and birthing people's concerns based on the information provided by them and then gave advice or recommended the person attend hospital. Staff told us the SHIP Maternity Referral system worked well in triaging women and birthing people and which has helped improve the service provision.

The trust carried out a post-partum haemorrhage (PPH) audit from January to March 2023. The result showed that 97% of women and birthing people had a PPH score documented antenatally, at admission and intrapartum when they presented to the maternity unit in labour. Staff performed well in the screening, assessment of risk factors for PPH in labour and documentation of timing of events. A consultant obstetrician was involved in all cases an estimated blood loss greater than 2000ml and consultant anaesthetist was involved in 90% of cases. Staff were not meeting trust target in activation of major obstetric haemorrhage call (53%), completion of the PPH proforma (6%) and complete documentation of PPH records (14%). There was no action plan in place to address the areas of low compliance. Following this inspection, the trust advised during the factual accuracy process that a thematic review of PPH cases had been carried out, which was presented at the December 2023 maternity and neonatal committee meeting with the conclusions and action plans. The action plan will be tracked via the patient safety forms. We noted that 2 of the recommendations in the action plans had been completed and the rest were in progress and within the deadline.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring safely. Leaders audited how effectively staff monitored women and birthing people during labour having continuous CTG.

The October 2023 audit of compliance for the period 1 July 2023 to 31 July 2023 showed that staff did not complete ‘fresh eyes’ and ‘fresh ears’ at the right interval in line with national guidance. For example, staff completed the hourly ‘fresh eyes’ assessment in 18% of cases and 44% of CTGs were reviewed at intervals of greater than 2 hours. This falls well below the expected standard for the national ‘Saving Babies’ Lives Care Bundle’ (SBLCBv3) and posed a risk for users of maternity services in the hospital. However, the result showed clear interpretation and management following a CTG review. Following this inspection as part of the factual accuracy process, the trust advised that the service was undertaken a deep dive audit of the hourly fresh eyes of paper and electronic CTGs. Findings from an initial review of the

on-going deep dive of 49 intrapartum CTG's, which had been partially reviewed demonstrate improvement in compliance in the January 2024 audit for the period of 1 December 2023 to 31 December 2023. The initial result showed that staff completed hourly fresh eyes in 65% of cases between 1 hour and 1 hour 15 minutes. The review was on-going and result were not available for other parameters including the fresh ears review.

In the same period, staff completed hourly fresh ears in 13% of cases and 1 to 2 hourly fresh ears in 63% of cases. The audit demonstrated that 87.5% of cases included in the audit met the four-hour target. Although compliance with hourly fresh ears was noted as low in the audit, it was acknowledged that the local policy was being updated to reflect national policy of four hourly reviews. We escalated our concerns with the low compliance in the completion of the hourly fresh eyes and fresh ears assessment to senior managers. Post inspection, the trust advised that the audits was completed only on their electronic record system and in some cases the paper CTG was also used to document fresh eyes and fresh ears and therefore would not have been included in the July 2023 audit. The trust had undertaken an ongoing review of paper CTGs records, which they believed would improve compliance and demonstrate the actual results in both audits. The service was implementing digital CTGs, which would enable a digital note on the CTG and would provide a single method to record and audit fresh eyes and fresh ears reviews. The service was planning on undertaken a re-audit in January 2024 and intend findings to be included in the mandatory training. The importance of timely fresh eyes was included as a specific topic in the daily safety huddles in the service.

The recording of CTGs we looked at during inspection had been undertaken correctly, with the expected details added, checked, and countersigned. We saw evidence that staff had completed hourly reviews of fresh eyes and fresh ears during inspection. These records were linked to the electronic records and were seen in records reviewed on this system. Paper copies of CTG were stored securely.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Staff screened women and birthing people for depression using a specific questionnaire referred to as the 'Whooley questions.' The questions are a tool which is designed to try and identify two symptoms that may be present in depression and is a recommendation by the National Institute for Health and Care Excellence (NICE). Information related to individual psychological risks was added to the electronic record and was shared at handovers between shift changes. The electronic record system had a section for alerting staff of any mental health or psychological risks. Women with mental health concerns or issues were supported by the service perinatal mental health team.

The service had launched 4 continuity of care team to support vulnerable women, people from ethnic minority groups, and those that lived in the military base in the area. Each team consisted of 8 midwives and staff told us they were not part of the service escalation team.

The service had a tongue tie clinic every Wednesday and were planning to expand the provision to the 3 days a week to support babies who required tie division and had problem with feeding.

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a consultant midwife and an obstetrician to discuss risks and options available to create a suitable birth plan together.

Maternity

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the women and birthing peoples' care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Where concerns required escalation, staff used the principle of communicating the situation, background, assessment, recommendation (SBAR tool), following standardised prompt questions in 4 sections. We saw records of SBAR having been used.

During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared and very detailed. Staff had regular safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person. Where a doctor's review was required on the maternity wards, this was communicated via a specific folder to the duty house officer. Handovers were held in a confidential area and white boards were in secured areas where only staff had access to. This was an improvement since the last inspection.

We observed good management and discussion of complex cases by multidisciplinary staff. The service had a high number of women and birthing people with a high body mass index (BMI) and there were process and pathways in place to safely care for them. The service was looking at implementing a one stop approach in the clinics to care for women and birthing people with diabetes and mental health. At the time of the inspection, the service was trialling a home glucose tolerance test for some of the women and birthing people to minimise risks, improve outcomes and reduce the did not attend (DNA) rates. Staff told us the home glucose tolerance test was available in 7 languages for women whose first spoken language was not English.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff completed the Newborn and Infant Physical Examination (NIPE) screening for newborn babies. There was a designated room for doing this and midwifery staff trained to undertake the assessment completed the assessment with the parents present.

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

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Midwifery Staffing

Staffing levels did not always match the planned numbers on each shifts putting the safety of women, birthing people and babies at risk. However, there had been recent recruitment and managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between April 2023 and September 2023 there were 113 red flag incidents. This was mostly related to delayed or cancelled activity and delay between admission and induction of labour.

From April to September 2023, the service reported an unfilled shift rate of 23%.

The ward manager adjusted staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas and acuity. For example, when we first arrived on the antenatal ward, staffing levels were correct at 2 midwives and 1 midwifery support worker. Soon after arrival, 1 midwife was taken to cover another maternity area with high acuity. The number of women and birthing people at the time was manageable with this reduction according to staff.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

Staffing was monitored by senior managers daily at the daily maternity and SHIP regional situation report meetings.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and birthing people accessing the service. The matron of the day completed the staffing acuity tool every 4 hours. The service used a traffic light red, amber, green system to determine the capacity of the unit. Green status meant the unit was functioning at normal capacity, amber status meant there were insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and red status would lead to a decision to close the unit. The unit leader updated the traffic light status 4 times during a 24-hour period.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in February 2020. This review recommended 230.30 whole-time equivalent (WTE) midwifery staff Band 3 to 7 compared to the funded staffing of 222.92 WTE, a shortfall of 7.38 WTE staff. We noted the report did not include the recommendation for the senior management team (band 8) staff. The report however recommended a significant uplift of staffing to include 19.13 WTE midwives and a reduction in 11.75 WTE support workers.

The service was now funded for 235 WTE midwifery staff and as of September 2023, they had 223.8 WTE in post. The service had low vacancy rates. As of September 2023, the service reported a 4.7% or 11.1WTE, vacancy rate.

The service had recruitment and retention plans and recently recruited 15 internationally trained midwives. The plans also included domestic recruitment of newly trained midwives, increasing student numbers, maternity support worker apprenticeship to midwifery programme and conversion of nurses to midwifery programme. We noted that 10 registered nurses were on the conversion to midwifery programme and the first cohort were due to graduate in 2024. Two maternity support workers who were on the midwifery apprenticeship programme had been funded to complete a formal midwifery training at a local university. To further increase the intake of student midwives placed in the maternity service, the trust had introduced a student placement for 16–17-year-old to undertake a ‘T level study’ (1-to-2-year practical post GCSE study programme). The trust offered placements in the hospital and community areas to give students experience of different areas of maternity care and to encourage students to consider applying for a midwifery training.

The service had low turnover rates and reducing sickness rates for midwifery staff. From October 2022 to September 2023, the service reported an average of 1.1% turnover rate and 5.2% sickness rate.

The service had several specialist midwives in post, who covered areas such as diabetes, public health, screening, digital, PNMH, perineal, preterm, infant feeding and bereavement. The public health midwife had been in post since 2021 and had 2 band 3 staff supporting her.

The service had employed 2 bereavement midwives and had 10 bereavement champions that had completed additional training and were competent to complete postmortem consent.

The infant feeding team had a lead midwife, 2 part time infant feeding midwives and a full-time midwifery support worker.

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

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Data supplied by the trust during the inspection, showed appraisals completed for maternity staff was 91%. A practice development team supported midwives. A practice development team supported midwives. The team included a matron, 4 practice development lead midwives and a band 4 maternity associate practitioners.

Managers made sure staff received any specialist training for their role. For example, some midwives had received funding for specialist training including master's level courses in advanced midwifery practice and the professional midwifery advocate course.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had zero vacancy rate. Senior managers told us they had over recruited medical staff to ensure appropriate skill mix, to cover maternity leave and due to restriction of the middle grade rota. The service had an extra1.46 WTE consultants, 2 WTE registrars and 2.95 WTE junior doctors than the required establishment at the time of the inspection.

The service had low turnover and sickness rates for medical staff.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

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

The service always had a consultant on call during evenings and weekends.

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

Records

Maternity

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

Women and birthing people's notes were comprehensive. The trust used a combination of paper and electronic records. We reviewed 8 paper records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Staff stored records securely. Staff locked computers when not in use and stored paper records in locked cabinets. This was an improvement from the last inspection.

Staff recorded women and birthing peoples' notes on the electronic patient record (EPR). We reviewed 8 records and found they had been fully completed, were detailed, and had been updated regularly. Records included evidence of antenatal appointments, ultrasound scans and contact with triage.

Staff with authority to access the records could do so with ease, when it was working well, using individual secure log on. Staff on the maternity wards told us the electronic record system was not always opening quickly and they were delayed at times getting access. We witnessed this on the antenatal ward, on the second day of our visit. It took more than an hour before access could be achieved by staff.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. There was a clear process to follow after a medicine incident occurs however there were high number of medicines incidents reported in the maternity service in the past year.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them. Codes were used for any medicines not given, indicating the reasons for this. We saw pain relief had been prescribed in all the records reviewed.

Staff reviewed women and birthing people's medicines regularly and provided advice about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked. A pharmacy technician had responsibility for attending wards and checking what medicines required a top-up. A hotline was provided for any urgent requests for the pharmacy team. A member of the pharmacy team attended the ward to ensure any take home medicines were noted and prepared in a timely manner. Midwives and doctors had access to the up to date British National Formulary when needed.

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

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and electronic record system for the 10 sets of medicines records we looked at were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. From October 2022 to September 2023, the trust 3 maternity services reported 61 medicines incidents. The top medicines incident's themes were administration of medicines to patient and prescribing process. We were told safety officers reviewed medicine errors and shared information, which was communicated at handovers or through emails. We saw information indicating a particular medicine was being focused on, with poster display in the clinical room on the postnatal ward. Staff explained and gave examples of additional training implemented following a medication incident. Staff learned from safety alerts and incidents to improve practice, with updates from the educational team each month.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. Staff, including student midwives told us they raised a matter on this system, and it went to the safety team, who then undertook the investigation. Midwives or others may be part of the investigation, depending on their involvement. Learning from the outcome of an incident review was communicated at safety huddles, handovers and via emails. If needed, staff members attended additional training or completed a reflective summary. We reviewed 10 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events on any wards from October 2022 to September 2023.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved women and birthing people and their families in investigations and shared information under duty of candour and draft reports with the families for comment. This was confirmed in governance reports and in the 3 cases we reviewed.

Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff.

Staff reported serious incidents clearly and in line with trust policy. From October 2022 to September 2023, the service reported 11 serious incidents. In the same period the service reported 1,501 incidents of which 12 were graded as moderate harm and above.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. There was evidence that changes had

been made in practice because of local safety incident investigation and national maternity publications. For example, the service had updated the 'did not attend (DNA) guideline' in April 2023. The new guideline included a clear flow charts of DNA pathway for screening, DNA scheduled care appointment**,** and DNA community antenatal and postnatal appointment.

Following a learning from an external thematic review around Apgar scoring (a standardized assessment for infants after delivery), the service was developing a handover tool between obstetrics and neonates to ensure the correct personnel was present at delivery. The birth centre now had a neonatal resuscitation room, staff told us this improvement was made following learning from 2 external investigations around umbilical cord prolapse.

The trust made 5 maternity neonatal safety investigation programme (MNSIP) referrals between May and October 2023. This related to 2 cases of potential severe brain injury, 2 intrapartum still birth and 1 early neonatal death. We saw example of improvements to practice following external incidents investigation. For example, the service had updated the trust sepsis triggers list and NEWS scoring system on their electronic records. The service had completed a staff survey which looked at the culture civility (respect) within the maternity units to obtain feedback and drive improvements.

Managers debriefed and supported staff after any serious incident.

At the time of the inspection, there were 86 incidents open for more than 60 working days, of these 30 incidents had been reviewed and 56 were awaiting final approval from senior managers. This was an improvement since the last inspection. Staff told us there had been improvements in the review and closing of incidents backlogs. The service only had 2 open serious incident and one of which was a complex case.

Is the service well-led?

Good ↑

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

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

There was a clearly defined management and leadership structure. The hospital maternity leadership team consisted of a care group director, clinical director obstetrician and a divisional director of midwifery. They were supported by a deputy director of midwifery, 6 matrons, a consultant midwife, business manager and specialist midwives. Staff told us the trust had invested in the leadership of the service to support staff and drive improvement. Since the last inspection, the service now had matrons for well-being, governance and 'quality and transformation'.

Maternity

Leaders were visible and approachable in the service for staff. Some staff on the antenatal and postnatal wards told some line managers were less approachable and visible. However, staff on the labour ward, birth centre, triage, day assessment units and clinics told us the trust leadership team and the service leaders were visible and approachable in the service for women and birthing people and staff.

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

The service was supported by maternity safety champions and non-executive directors. The safety champions completed regular walkabout of the maternity service every fortnight.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. For example, a staff member had been funded to attend Florence Nightingale leadership course in April 2023 and 2 other staff had been approved to start a university level leadership course in March 2024.

We noted that several senior midwives had completed or were on a master's leadership training module. For example, the quality and transformation matron had completed several leadership courses, was on a clinical education improvement fellowship programme.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. This was an improvement from the last inspection. Staff could explain the vision and what it meant for women, birthing people and babies. However, some staff on the antenatal and postnatal wards were not able to tell us about the maternity service vision or strategy. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. The 2020-2025 strategy was focused on three priorities: provide high quality safe care, improve the health and wellbeing of mothers and babies and delivering individualised care. Maternity services also had a wellbeing strategy for staff that was led by the wellbeing and retention matron.

The strategy was aligned with national priorities including Better Births and the NHS long term plan.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Maternity

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

Staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

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

Staff we spoke with us were proud to work at the service and reported being happy in their work. We were told by a non-clinical staff member the culture was open, relaxed and everyone was helpful. Caring about each other and taking the time to check up on colleagues were factors described positively by staff. Teamwork and good practice development were said to be a positive factor of working at the trust.

Student midwives told us it was a 'brilliant trust,' and they felt very positive, wishing to stay at the trust after qualifying. We note that on the postnatal ward, there was a designated bay for the final year student midwives, and they had been allocated a midwife to oversee their work and they had direct and indirect support. The student midwives spoke positively about this opportunity and how it has helped developed their skills on discharge planning and other competencies needed to achieve their proficiencies.

The internationally trained midwives we spoke with told us they had been well-received, welcomed, and had good line managers. The theatre team were described as supportive, approachable and in general of having a positive culture. The Band 7 midwives and coordinators were described positively to us, including being approachable, supportive and 'great.'

Staff spoke positively about the safety culture, collaborative working, and a no blame culture following a serious or adverse incidents. The service had a system in place to support staff following a serious or adverse incidents. This includes hot debrief, serious incident support pathway and link with the professional midwifery advocate and wellbeing matron. Staff also had support from the link safety team, follow-up wellbeing checks and a critical incidents stress management debrief.

Maternity services had a lead freedom to speak up guardian, supported by 5 midwife ambassadors and 1 midwifery support worker ambassador. The profile of speaking up was to be a focus in November 2023, with a 'trolley dash' to communicate this, as well as well-being.

The service had a strong focus on improving staff wellbeing, which was one of the care group priorities. The service had organised a maternity wellbeing event in February 2023 which focused on support of staff following a national maternity review finding. The event was organised by the professional midwifery advocates (PMAs), speak up guardian and dietitian and included programmes to support holistic wellbeing, career development and compassionate conversation.

Maternity

The service had a lead for well-being, seconded until March 2024 in a full-time capacity. They had been responsible for implementing professional midwifery advocates (PMAs), following the change from supervisory sessions. The local maternity and neonatal system had a plan to have 17 PMAs covering all areas and available to provide restorative supervision.

The lead for well-being had developed post incident support and a process for communicating and escalating concerns. Some of the focus was around educating staff to use the right terminology to convey escalation of deterioration in women and birthing people.

The well-being lead had planned 'Nurturing November,' as a way of promoting civility in the maternity service. This was in response to a staff survey on this area. Staff told us the service was in the process of rolling out a civility and respect toolkit. Since the last staff survey, which had lower results than expected, the service had focused on morale and it was felt there was a better atmosphere, staff were happier and there were various avenues for staff to be listened to.

Staff had been empowered to make decisions and there was an improve well-being app for making suggestions. Wellbeing was being monitored via the app with a 'good day' rating currently at 85-86% during inspection. 'You said, we did' actions to improve staff wellbeing were generated from this. Leaders had introduced a 'time for tea' initiative on the wards in November 2022, with time in the morning and afternoon for staff to come together, share a drink and improve team working. We were present on the maternity wards when this happened, and we observed a friendly and inclusive atmosphere.

Pets as therapy had been used on the maternity wards for staff and extended stay mothers and birthing people well-being, which was introduced January 2023. The service had furnished staff rooms with heat and massage recliner chairs in March 2023 to promote staff wellbeing. A wish list for staff well-being was displayed for members of the public to contribute to if they so wished.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service had several ethnic equality projects aimed at addressing inequalities and improving outcomes. This includes engagement with the Moriah project (an organisation focused on dismantling complex social inequities and building thriving communities of colour), cross cultural women's group and local university and refugee groups. Staff also engaged with different ethnicity groups, which includes the Filipino, Ghanian and Nigerian community associations.

As part of a learning disabilities and neuro diversity project, a multi-disciplinary team led by the specialist midwife for public health were working together to improve the service for those who have a learning disability by producing a maternity passport. The passport had been produced in conjunction with a service user and staff group from the learning disability team in the local community. The service had plans to produce a learning disability easy read birth plan and post-natal plan. The service was raising funds to be able to put together boxes with photo memories for parents and the baby when due to some circumstances a baby was not going home with the parents.

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

Maternity

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

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

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

From October 2022 to September 2023, the trust maternity services received 36 complaints, which were mainly related to treatment and care received and staff attitude.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions.

The service held various governance meetings which fed into the trust board meeting. This includes the quality and performance committee, maternity committee governance report, bi-annual maternity and neonatal committee and networked services division governance meetings.

Governance meeting agendas included discussion around all aspects of governance and oversight of the service such as performance data, training, serious incidents, internal and external learning presentations, risk management, patient experience, infection control and workforce.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Staff told us following the recommendation from an external regional assurance visit in June 2022, the service had cleared most of the backlogs of policies and guidelines that needed to be reviewed. Of 10 policies and guidelines reviewed during and after the inspection 9 were clear and up to date another, the infant and child abduction policy, due for review since 24 June 2023 had been given a 3-month extension date to September 2023. Staff received an update during handover, emails or displayed posters when a policy or guideline had been updated.

Maternity

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits such as the Perinatal Mortality Surveillance report and the National Maternity & Perinatal Audit (MBRRACE). Outcomes for women and birthing people were generally positive, consistent, and met expectations, such as national standards on third- and fourth-degree tears and the friends and family test. The trust was not an outlier on any national audits however the service was not meeting the trust target on post-partum haemorrhage, smoking at delivery and closure of complaints.

In the MBBRACE 2021 audit, the service scored lower (better) than comparator group on stabilised and adjusted neonatal mortality rate including due to congenital anomalies, similar on extended perinatal mortality rate. However, the service scored 5% higher than average on the stabilised and adjusted still birth rates compared to the comparator group. There were action plans to address areas of poor performance. Managers and staff used the results to improve women and birthing people's outcomes.

In the 2023 General Medical Council (GMC) 2023 survey, the service performed similar to national average on 16 outcomes and were in the top quartile on two outcomes. The result of this year survey was better than the 2022 survey where the service scored below the national average on 1 outcome workload but now in line with the national average. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Managers monitored risk across maternity services on the maternity services risk register. Top risks across maternity services were midwifery staffing, cardiotocograph (CTG) interpretation and the electronic records system. These risks were mitigated by agreement being secured from trust board to invest in additional midwifery staffing and ongoing audit and early escalation of delays to induction of labour. Also, a working party was completing a review of nitrous oxide exposure in the maternity units.

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

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

Maternity

The service collected reliable data and analysed it**.** There was a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Key information from the dashboard, audits and performance data were reported on the trust board papers and displayed across the service for staff, women, birthing people and public to access.

Data or notifications were consistently submitted to external organisations as required. This was an improvement since the last inspection. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme, maternity dashboard, and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure**.** The service used an electronic records system. Computer systems were used in a safe manner, with secure access for authorised persons only. Screens were not left open when not in use.

Data or notifications were consistently submitted to external organisations as required.

The maternity service overall was part of a digital equality project to review people's experiences of accessing their maternity electronic records through an app on a smart phone. The project aimed to review the impact of digital literacy on health inequalities especially in relation to pregnancy in young people and ethnic minority women and birthing people.

The service had several quality improvement projects around information management. This included artificial intelligence (AI) automation referral inbox for booking appointments and maternity notification for women and birthing people who presented to the emergency department.

The service also had innovative AI projects to transform automated booking of scans consultants' appointment, patients receiving email confirmation of booking within 24hrs, and the community midwives' diary app enhance booking.

Engagement

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

Leaders worked with the local maternity and neonatal voices partnership (MNVP) to contribute to decisions about care in maternity services. The service had strong links with the local MNVP, and they were involved in the governance of the service by attending the monthly maternity and neonatal committee meetings. The MNVP was working with the trust on co-production to improve services and met with representatives from the trust and service users every 6 weeks to progress this work.

The service welcomed feedback from women, birthing people, and families. For example, staff told us that women and birthing people had been engaged in the choosing of the style of beds that was recently purchased in the induction bay. People could feedback to the service through surveys, complaints and through the local MNVP. The MNVP meetings were

held online and in person and included discussions around feedback, national maternity report recommendations and breastfeeding support. In the July 2023 MNVP meeting, the group had discussed around LGBTQIA and the need for training plans for staff. This was to further improve their skills and competency to effectively safeguard and provide LGBTQIA+ patients with a positive and equitable maternity service.

The MNVP held regular listening events, drop-in sessions participate in 15 steps and engagement with community groups. For example, we saw that the MNVP had carried out drop-in sessions in May 2023 in triage, postnatal wards, induction bays and midwifery led unit to engage with staff, women, and birthing people. They were involved in co-production works and various quality improvement (QI) project such as the digital poverty project aimed at improvement outcomes for the people from ethnic minority groups and young mothers.

The MNVP chair was involved in the local maternity and neonatal system equity project group to improve choice and consent for women and birthing people using maternity services. As part of this project the MNVP had held engagement events with the 'Muslim Sister's' group in September 2023.

From October 2022 to August 2023, the friends and family test survey result showed 99% compliance against 95% target.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, Portsmouth University Hospital NHS trust scored about the same for 46 questions, 'somewhat better than expected' for one question and 'worse than expected' for one question. Areas for improvement identified by the survey included involvement of partners, access to speaking with a midwife and ensuring mothers always felt listened to during and after birth.

The maternity staff survey 2022 result showed that the trust performed similar to the trust average on 8 standards and below average on 13 standards. The service scored below average on areas such as inclusion, involvement, work pressure, team working, raising concern, burnout. The trust had a transformation programme to address areas of improvement and each month focused on different standards for improvement. Other means for support for staff following the survey includes professional midwifery advocates (PMAs) support and survey, incident contact sheet for staff support, psychological support leaflet, listening events in November 2022 with the trust leadership team and various wellbeing event.

Learning was based on a thorough analysis and investigation of things that go wrong. All staff are encouraged to participate in learning to improve safety as much as possible, including participating in local, national and safety programmes. The service held regular 'sharing, caring, and learning events' to discuss learning from recent incidents including serious incidents. Staff spoke positively about the sharing, caring, and learning events which can be attended in person or virtually and agendas were shared ahead. The learning event was exemplary and student, staff and internal and external guests were also invited such as chief medical officer for England. Past events had covered learning from the continuity of care model, fetal monitoring, and the service intelligent automation transformation programme- safety though communication.

The service recently held workshops and maternity learning events which focused around caring for people from ethnic minority groups mothers in Portsmouth following recent incidents cases. The service had received funding from the National Institute for Health and Care Research (NIHR) to engage with 4 different ethnic community group as part of a QI project. The service had developed a specialist midwifery post for engagement with ethnic communities in various research projects to improve outcomes.

Managers engaged with staff through various medium such as regular listening events, newsletter, director of midwifery message newsletter, wellbeing app, bi-monthly staff meetings, 'Sharing, caring and learning events' staff forums. Staff could attend the staff meetings in person or virtually. Managers had discussed the staff, score, and civility survey with staff at the September 2023 staff forum meetings.

The service also engaged and celebrated staff and team success and supported good staff practice through the maternity newsletters, monthly nomination cards, thank you cards, and trust staff awards. The July 2023 newsletter highlighted that one of the continuity team had won the team of the month. The September 2023 director of midwifery message newsletter highlighted that the trust was considered an outstanding student placement following a Nursing and Midwifery Council (NMC) visit.

The service always made available interpreting services for women and birthing people and collected data on ethnicity.

Leaders understood the needs of the local population. For example, the service held 2 joint smokefree events during 'Stoptober' with the acute side, and the community smoke cessation service. This was aimed at pregnant smokers, patients, visitors, and staff which was very well attended, and referrals accepted.

The maternity non-executive director safety champion had taken up a role of a breast feeding infant (BFI) guardian to support the team delivering BFI through board level discussions and wider trust engagement and challenges in achieving BFI accreditation. The service recently achieved the level 2 BFI accreditation.

Feedback from women, birthing people, and their partners we spoke to during inspection was positive about the care, staff professionalism, continuity of care team, pain relief, tongue tie assessment and clinic. The only area of improvement was around breastfeeding advice. We received approximately 34 responses to our give feedback on care posters which were in place during the inspection. Of these responses the majority were mixed feedback and some positive feedback. Themes from the positive feedback related to care received, discharge, support, and experience. Negative comments or suggestions of improvement mainly related to communication, tongue tie, care received and staff attitude.

Learning, continuous improvement and innovation

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

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

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

The service had an active reproductive health and childbirth research team. The service was part of national research trials such as the multiple pregnancy registry for which staff had developed an elective caesarean risk rating pathway to prioritise the elective caesarean procedures in the service. Also, the national Rainbow Clinic study which aimed to understand the care needed in pregnancy following a stillbirth.

Maternity

Staff were encouraged and supported to complete a good clinical practice training to help support research and quality improvement projects in the service. For example, the service was using the trust quality improvement methodology Delivering Excellence Every Day (DEED) to improve the service. Quality improvement projects included but were not limited to improving the number of bookings for antenatal care by 10 weeks of gestation, improving the maternity service for people with a learning disability by creating a maternity passport with input from a service user group and providing smoking cessation services within maternity so women and birthing people did not have to access generic services in the community where they may feel judged.

The Southampton, Hampshire, Portsmouth, and Isle of Wight (SHIP) local maternity network had a healthier together app, which was used to support the maternity triage line and helped reduced the call volumes. The app was accessed by over 13,000 users monthly across the SHIP. The SHIP was currently looking at the ethnicity data and patient feedback on the use of the app to shape service delivery and drive improvement.

The midwives had completed training on contraception this year as part of their mandatory training. The service was rolling out training to obstetricians in offering an intrauterine contraceptive device (IUD, also known as the 'coil') at elective caesarean section which was funded by the sexual health commissioner. One of the specialist public health midwives was working with 2 registrars on a postnatal contraception QI project with regards to insertion of an IUD at caesarean section.

The service was setting up a smokefree pregnancy inhouse pathway in November 2023 which will include 2 maternity service stop smoking advisors. Pregnant smokers will be able to receive very brief advice, nicotine-replacement therapy and ongoing support to quit and stop smoking long-term from 2 specially trained maternity stop smoking advisors.

There was a team in the maternity outpatient's department which ensured that there was a vaccinator available Monday to Friday offering pertussis (whooping cough) and flu vaccines to women and birthing people. The service ran 2 BCG vaccine for tuberculosis clinics per week offering 22 appointment slots over the 2 clinics. This had enabled them to increase their BCG vaccination rate to above the 80% compliance rate from the previous 16% rate.

The maternity practice development team were the winner of the internal 2022 pride of Portsmouth award for working together as one team. They were also a finalist in a national publication in December 2022 workforce award under the development of bespoke midwifery preceptorship programme.

One of the practice development lead midwives won a national midwifery education trailblazer award for the maternity and midwifery forum in February 2023.

The feedback from the regional chief midwifery officer during the regional PMA visit highlighted that the trust stood out as an exemplar demonstrating supportive maternity leadership, a focus on staff wellbeing and a clear sense of a positive workplace culture.

A midwife had received the regional chief midwifery officer and a parliamentary award for the equity work and care to support the women and birthing people from the Bangladeshi community.

The service had received the regional chief midwifery officer award for the joint work that they did in developing a system for daily safety huddles and mutual aid across maternity services in Wessex.

One of the matrons was nominated for the 'Working Together always improving award' in the August 2023 pride of Portsmouth award.

Maternity

The maternity theatre team had developed a multi-disciplinary safety checklist to facilitate continuous fetal heart monitoring during labour epidural analgesia insertion. This was in line with national maternity and safety incidents recommendation. The service carried out a staff survey on the use of the safety checklist. The findings showed that 86% of clinical staff felt the checklist encourage communication between members of the multidisciplinary team and contributed to fetal and maternal safety. The safety checklist and learning from the implementation had been shared at learning events and published in an anaesthetist's journal in 2022.

Following the emergency department alert digital automation quality improvement project, the maternity service was now aware of women attendance in the emergency department within 12 hours. They were also able to analyse any 12 months previous attendance and produce a safety risk report. Since the implementation, the service received over 75 admission alerts and 10 predicted admission alerts weekly. The use of the automated digital system was in response to a national safety recommendation on alerting maternity services of emergency department admission following the death of a mother in UK in 2021. The service had won a national publication digital award 2023 for improving back-office efficiency through digital.

Outstanding practice

We found the following areas of outstanding practice:

- The service and the maternity and neonatal voices partnership (MNVP) working together was exemplary, active, and engaged well with the service to drive improvement, service delivery, co-produced leaflets and involved in quality improvement projects.
- The service was part of digital artificial intelligence projects which improved the notification of women and birthing people that attended the emergency department and the maternity booking appointment system.
- A midwife had received the regional chief midwifery officer and a parliamentary award for the equity work and care to support the women and birthing people from the Bangladeshi community.

Areas for improvement

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

Queen Alexandra Hospital

Action the trust SHOULD take to improve:

- The service should ensure staff complete timely reviews for each woman in triage line with the trust policy.
- The service should continue to ensure that staff are up to date with the maternity and safeguarding mandatory training modules.
- The service should ensure staff complete and document fresh eyes and fresh ears observations in line with national guidance.

Maternity

- The trust should continue to monitor the postpartum audit action plan to help improve compliance in the activation of the major obstetric haemorrhage call and full completion of the women and birthing people PPH proforma and records.
- The service should address the delay in the accessing of electronic records by staff.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 4 specialist advisors and 2 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.