University Hospital Southampton NHS Foundation Trust

Princess Anne Hospital

Inspection report

Coxford Road
Shirley
Southampton
SO16 5YA
Tel: 02380777222
www.suht.nhs.uk

Date of inspection visit: 15 May 2023
Date of publication: 11/08/2023

Ratings

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

Our findings

Overall summary of services at Princess Anne Hospital

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Princess Anne Hospital.

We inspected the maternity service at Princess Anne 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.

Princess Anne Hospital provides maternity care and treatment to women, birthing people and babies from Southampton and surrounding areas, as well as providing more complex maternity and neonatal care to others from the Local Maternity and Neonatal System (LMNS). The LMNS covers Southampton, Hampshire, the Isle of Wight and Portsmouth. Staff at the hospital delivered 5220 babies between April 2021 and March 2022 and there were 480 births in April 2023.

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

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

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

We did not review the rating of the location therefore our rating of this hospital stayed the same, Princess Anne Hospital is rated good.

We did not inspect the other service run by University Hospital Southampton NHS Foundation Trust, the New Forest Birth Centre, as it is currently dormant for delivery of babies.

How we carried out the inspection

During the inspection we spoke with 23 staff including the chief nursing officer, director of midwifery, head of midwifery, obstetricians, doctors and midwives, the non-executive safety champion and the Maternity Voices Partnership chair. We attended handover meetings, reviewed 8 records and spoke with 2 women or birthing people and families.

We received over 300 'give feedback on care' forms through our website from women and birthing people, of which about a quarter were positive. A quarter were negative and about half of all responses included mixed feedback about their experience.

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

Maternity

Good ➔➔

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

- Most midwifery staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well and 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. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services continually.

However:

- Staffing levels did not always match the planned numbers which may have caused delays to care and treatment.
- Medical staff had not completed all mandatory training, such as safeguarding.
- The service estates lacked investment and affected the experience for women and birthing people as well as staff.
- The security of the wards was not always effective putting the safety of women and birthing people and babies at risk.
- Checks on emergency equipment were not always completed on a daily basis.
- There had been a general improvement in infection prevention and control, although we continued to find isolated incidents.

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory training in key skills, however not all staff had completed up-to-date training.

Not all medical staff were up to date with their mandatory training. The trust provided training compliance for medical staff, which showed that junior medical staff training fell short of trust targets of 95% for information governance and

85% for all other training. Fire safety training had been completed by 18 of the 34 staff listed on the training, information governance was completed by 16 staff, basic life support had been completed by 18 staff. Only one junior medical staff member had completed all of the mandatory training and only 2 of the 19 training sessions had been undertaken by all junior medical staff.

Midwifery and nursing staff received and kept up to date with their mandatory training. Between 83 and 94% of midwives, maternity nurses and maternity support workers had completed this training, which included basic life support and perinatal mental health. Most of these staff were also up to date with other mandatory training, such as fire safety, moving and handling, and infection prevention and control.

The trust provided other training that was specific to maternity staff. However, records for May 2023 showed similar trends to other training, as the level of completion by junior doctors was lower than that for midwives or consultants. Sixty eight percent of junior doctors had completed fetal surveillance training, which did not meet the trust target of 85%. Records showed 95% of consultants and 92% of midwives had completed fetal surveillance training.

The service made sure multi-professional simulated obstetric emergency training was available, although not all staff had received it. The service provided a whole day for staff to complete scenarios, which included neonatal life support and pool evacuation training. Records for May 2023 showed that 94% of midwives, 63% of junior doctors and 79% of consultants had completed their obstetric emergency training, which fell short of the trust's 95% target for this training. The impact of lack of simulated training is that during emergencies some staff may not respond effectively.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. There was an emphasis on multidisciplinary training, which included midwives, junior doctors and consultants learning together. This ensured all staff were given the same information, they developed better working relationships by learning together, which led to better outcomes for women and birthing people and babies. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Staff were tested at the end of the training day to ensure they had absorbed the information presented.

Training schedules also included additional maternity courses, such as a midwifery professional study day, medical devices and Avoiding Term Admissions to Neonatal units (ATAIN) e-learning module.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Overall staff training compliance figures were reported in governance meeting minutes. This recognised the lower compliance for junior doctors, due to a shortfall in staffing. Action plans were in place and completion rates had increased by 10% in the last 12 months.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Not all staff had received training on how to recognise and report abuse.

Not all staff had received recent training specific for their role on how to recognise and report abuse. Information provided by the trust showed medical staff compliance for safeguarding adult and child protection training only went to level 2. National safeguarding intercollegiate guidelines state that all staff risk assessing women and birthing people should complete training to level 3. Of the 36 junior doctors on the maternity rota, 19 had not received adult

safeguarding and 17 had not received child protection training at level 2 in the last 3 years. The information we received showed that 7 junior doctors may not have had any safeguarding training since August 2016. This meant the trust could not be assured that safeguarding needs were accurately identified or that all staff had the skills and knowledge to make appropriate referrals.

Following the inspection the service leaders informed us that obstetricians did not work independently of midwives and would never be the only clinician dealing with safeguarding issues. An agreement was therefore reached in 2021 for the safeguarding training requirement that all obstetric medical staff (except trainees) only needed to complete level 2 safeguarding training. The care group clinical lead and director of education were the exception required to complete level 3 training.

Records for April 2021 to April 2022 showed that 91% of midwives and maternity support workers had completed both Level 3 safeguarding adults and child protection training against a trust target of 85%.

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 staff developed birth plans for women and birthing people with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could turn to when they had concerns. The team was made up of a band 7 lead midwife, supported by a band 6 midwife, a domestic abuse midwife and an administrator. They reviewed safeguarding referrals and made sure women, birthing people and families received the appropriate interventions and support when needed. Staff explained safeguarding procedures, how to make referrals and how to access advice. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

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 demonstrated their understanding during our conversations with them and showed how they had considered the needs of patients with protected characteristics.

Staff followed the baby abduction policy, although not all staff undertook baby abduction drills. Staff explained the baby abduction policy, but we saw that not all ward areas were secure. This was because there were estates issues with door security. On F-level there was no intercom system to allow the receptionist to speak with visitors before allowing them access. On E-level, doors to Broadlands Birth Centre did not always shut when left to self-close. After the inspection we raised these security issues with the trust, who responded swiftly. F-level had an intercom system installed and the doors on E-level were adjusted to make sure they always closed properly. Staff in the Broadlands Birth Centre had not practised what would happen if a baby was abducted within the previous 12 months of the inspection.

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. They kept most equipment and the premises visibly clean.

Maternity

Most maternity service areas were clean and had suitable furnishings which were clean and well-maintained. We saw that most areas, such as corridors and patient rooms, were visibly clean and free of dust in folds in chairs. However, there were some issues of infection control risks. We found a towel in one baby resuscitaire was soiled and had not been changed after the equipment was previously used. Temperature checks of the milk fridge had not been fully completed, leading to a risk of deterioration of stored breast milk. Infection control was identified as an issue in our last inspection report and although overall there had been some improvement, there continued to be incidents of poor practice.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff told us they recorded when they had cleaned each area on checklists, which provided information to other cleaning staff and assurance that areas that had not been cleaned were identified.

The service generally performed well for cleanliness. Staff performed monthly ward round cleaning audits for each area and completed a documented audit. Staff recorded information on a cleaning action required report which stated areas for improvement. For example, March 2023 reports showed that limescale had built up on taps and needed to be removed. The overall audit data for April 2023 showed that compliance was 99%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff made sure their clothing was bare below the elbows, all areas stocked PPE at various intervals along walls as well as hand sanitiser. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 85%. The service did not report any hospital acquired infection incidents during April 2022 to April 2023.

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. Staff cleaned couches between use and it was clear equipment was clean and ready for use.

Environment and equipment

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

Staff did not always carry out daily safety checks of specialist equipment. The service had enough suitable equipment to help staff safely care for women, birthing people and babies. Service leaders monitored emergency trolley checks which contained the defibrillator and records for January to April 2023 confirmed that labour ward staff checked 97.8% of the time. However, ward compliance for the same period was lower at 87.8%. Managers developed actions including a review of the current process and identifying a clinical lead to be accountable for the checks. However, we found this was not entirely effective.

During the inspection we reviewed specialist equipment, including emergency adult and neonatal resuscitation equipment and observation equipment. We found daily checks were not always recorded, such as on the resuscitaires, as being carried out every day in the labour ward and the antenatal and postnatal wards. Daily checks of emergency equipment are vital to ensure staff have the appropriate equipment available immediately.

Women and birthing people could reach call bells and staff responded quickly when called. We saw that call bells were within easy reach and staff responded in a timely manner when these were rung.

Maternity

The design of the environment did not follow national guidance. Whilst there was security out of hours for access to Princess Annes Hospital the maternity service did not have a monitored entry and exit system at entrances to maternity wards, units and reception areas.

Staff told us of their concerns in not knowing who people were when arriving at the ward areas. We saw some doors did not readily close and were easy to leave on the latch. There were concerns at our last inspection about security. We raised these concerns at this inspection and the trust responded with an action plan. They made some immediate improvements to improve security including reducing the risk of tailgating at doorways and admitting people to maternity areas in a more controlled way.

The midwife-led Broadlands Birth Centre was described by staff as not as "homely" as they would like it to have been. Most birthing rooms were sparse and clinical, lacked ambiance and some had views only of industrial pipes. However, the rooms with a birthing pool had been adapted and had softer lighting and candles.

The storage cupboards in clinical rooms, such as those for medicines storage, were hard to clean surfaces and wooden domestic style cupboards. There had been limited evidence of significant investment to update the facilities fixtures and fittings in recent times.

The triage area configuration was narrow, which made it easy to make contact with patient curtains when they were drawn. One bed's curtains were adjacent to the entrance door, the foot of the bed and the midwives workstation, with its busy thoroughfare, meant it was very easy for these curtains to come into contact with people walking into and through the unit and potentially fail to provide adequate privacy. It was easy to hear everything discussed for the treatment of and conversation by staff with women and birthing people or when staff were on the telephone or speaking amongst themselves.

The service had dedicated maternity theatres, including an emergency theatre, a high dependency unit for women and birthing people, and transitional care beds for babies requiring a higher level of monitoring during and after delivery.

Staff had developed a bereavement suite at the end of the delivery suite, which women and birthing people could access and leave from without going through the delivery suite. The suite included two rooms, one for delivery and the other decorated in a comfortable, home style area for women, birthing people and their partners to rest in. The room included tea and coffee making facilities, as well as relevant literature. This was a recommendation in the Stillbirth and Neonatal Death charity (Sands) position statement (Bereavement care rooms and bereavement suites 2016).

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water. We saw this during our visit to the Broadlands Birth Centre.

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

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Records showed that the service had recently completed portable appliance testing (PAT) on all its equipment in January 2023.

Maternity

In March 2023 NHS England issued guidance on actions NHS trusts should take to minimise staff exposure to nitrous oxide. The service monitored staff exposure prior to this guidance and following had developed a risk assessment and action plan to consider the further actions they needed to take and how best to protect staff.

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

Ninety-one per cent of clinical staff had received ligature point and cutter training as part of basic life support training. The trust had a standard operating procedure (SOP) for the 'Management and Care of Ligature Cutters and Ligature Pack' which expired in August 2022. The SOP included details on how to store, check and use ligature cutters. The service provided evidence of ligature removal training. However, there was no data to show how many staff had received it.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman or birthing person. The trust completed an audit on staff compliance to the use of MEOWS charts and found that 80% of staff correctly completed them. All the observations that were recorded as not within normal parameters had been escalated to senior staff. The audit identified that some staff needed to receive additional training on how to appropriately record observations like respiration rates.

Staff completed antenatal risk assessments when women and birthing people booked for their care at the start of their pregnancy, we reviewed 8 sets of records and found that staff had completed all risk assessments for these patients. However, trust information showed full risk assessments of women and birthing people were not completed at each antenatal appointment. The maternity dashboard data for January 2023 to April 2023 showed that only 53% of women or birthing people had a completed risk assessment. The data was collected as part of the Ockenden report (2022) recommendations for safer care. Risk assessments are pivotal to making sure women and birthing people receive the right care. The service were reviewing data measuring for this as audits completed at a more local level (ward or unit) showed a greater compliance.

Following this inspection the service carried out an audit of 20 records for the period January to April 2023 and they identified a 100% compliance.

Staff used the five elements of the 'Saving Babies Lives Care Bundle version 2' (SBLCB), which are:

1. Reducing smoking in pregnancy

2. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction

3. Raising awareness about fetal movements

4. Effective monitoring of fetal monitoring during labour

Maternity

5. Reducing preterm birth

Leaders completed audits to show compliance to the SBLCB. These showed that 87% of women and birthing people were offered carbon monoxide (CO) monitoring in accordance with the SBLCB, which advises trusts to monitor levels at booking and at 36 weeks of pregnancy. The service also monitored women and birthing people who smoked and this showed 57% were referred to support to stop smoking. All women and birthing people were assessed for risks of fetal growth restriction at booking and 89% had a further assessment at 16-20 weeks gestation.

Audits showed that 100% of women and birthing people were given the 'Your babies movements' leaflet and that midwives discussed fetal movements at all antenatal appointments. Eighty nine percent of women who attended the hospital with reduced fetal movements had a computerised CTG.

The service collected ethnicity data on their maternity dashboard to make sure that Black, Asian and minority ethnic women and birthing people were placed on the right care pathways. This is because they are known to be at higher risk of having certain health conditions, like diabetes and high blood pressure.

Staff completed risk assessments for each woman or birthing person on arrival to the hospital, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised prioritisation risk assessment tool for maternity triage. Records showed that from January 2023 to April 2023 women and birthing people accessed triage 3,526 times. The triage tool used a traffic light, red, amber, green (RAG), system to help staff identify and highlight the most at risk patients to prioritise their care.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed time limits and national targets. The maternity triage waiting times for review audit for January to April 2023 showed midwives reviewed 86% of women and birthing people within 15 minutes of arrival.

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.

The referral service was based in a local ambulance hub, staffed by 3 midwives at all times. The service ensured a speedy response to all callers and prevented the need for staffing a telephone in the limited space available at the Princess Anne Hospital. The referral monitor included a list of who was coming in and essential details for midwives ready to receive the women and birthing people in the triage unit. All information was linked to the electronic records system the trust used.

Leaders monitored the telephone triage helpline traffic to identify themes for women and birthing people calling the helpline. Records from December 2022 to April 2023 showed that on average 90% of calls were answered within 30 seconds.

Staff knew about and dealt with any specific risk issues. For example, staff followed a Sepsis guideline when they identified abnormal observations during admission. Sepsis is an infection that can be life threatening if untreated and staff used a sepsis 6 care bundle for women and birthing people at risk of Sepsis. Managers monitored compliance and records for May 2023 confirmed that staff followed the correct procedure 100% of the time.

Also, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The December 2022 audit showed staff did 'fresh eyes' at each hourly assessment in 80 % of cases. Managers released a CTG peer review compliance update presentation in spring 2023 which showed there had been a gradual improvement over the previous year. The update discussed actions taken by leaders to ensure staffs knowledge, skills and compliance were in line with best practice and included plans to update the electronic patient records with prompts to remind staff to complete reviews on time.

Staff in theatres completed a WHO Stop point safety checklist, which is a safety check list to decrease errors and adverse events and increase teamwork. Audit data from November 2022 showed that overall staff completed the checklist appropriately 85% of the time. Service leaders set out actions to make sure staff understood why the checklist was important and planned a re-audit.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. The trust had a perinatal mental health lead midwife who covered the whole service and reviewed all new referrals, trained staff and liaised with the community mental health team.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The perinatal mental health lead midwife told us staff had benefitted from training in this area and they now received appropriate referrals as staff had increased confidence in caring for women and birthing people with mental health difficulties.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the SBAR (Situation, Background, Assessment and Recommendation) tool to handover patients to others. The communication tool prompts staff to record key information and recommendations about patients. Leaders monitored compliance and the January to April 2023 audit showed that 100% of staff in the audit used the tool correctly.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 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 the patients. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. At birth, staff completed a Neonatal Early Warning Score (NEWS) to effectively monitor neonatal observations. The tool used a RAG rated system to alert staff to those babies who may require additional or transitional care. An audit for January 2023 - April 2023 showed that staff completed the tool correctly most of the time. However, 30% of babies had one set of observations delayed or missed. The delays were attributed to feeding or prioritisation of maternal care and a problem with the electronic records system pulling information through to the correct field for data collection. Leaders identified the need to remind staff to manually add information into this field if needed.

Service leaders planned to continue with quarterly audits to ensure recording of observations for women, birthing people and babies are embedded and completed effectively.

Leaders monitored postnatal readmissions to identify key themes for women and birthing people re-admitted to the maternity services following discharge. Data for January 2023 to February 2023 showed there were 42 re-admissions. The reasons for re-admission were separated into mother or baby categories. Out of the 42 readmissions, 30 were for issues with babies (e.g. jaundice or extreme weight loss) and 12 women or birthing people who needed a medical review. In all cases the appropriate medical review was requested.

Midwifery Staffing

The service had issues with recruitment which reflected the national midwifery shortage. Staffing levels usually matched the planned numbers and the service mitigated any risks to prioritise the safety of women and birthing people and babies.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. Leaders used a nationally recognised staffing acuity tool and completed a maternity safe staffing workforce review in line with national guidance in May 2023. This review confirmed that the current establishment was correct and midwife staffing was at required levels 85% of the time. Records confirmed the required staffing levels were 207 whole-time equivalent (WTE) midwives band 5 to 8. In addition, the trust had 23 WTE specialist midwives which reflected national guidance.

However, staffing levels did not match the planned numbers on the day of our inspection. On the day of inspection midwifery staffing should have been 17 midwives and maternity support workers plus 1 supernumerary coordinator but we saw there were 13 midwives plus 1 supernumerary coordinator. On the day of our inspection the service was quiet with lower numbers of women and birthing people as inpatients. Although lower staffing levels were not ideal, this did not provide an unsafe environment in labour suite or triage, as these areas took priority for staffing levels.

On the day of inspection we attended the SHIP daily safety huddle, where each trust explained their staffing acuity for the day and if help was needed to support each other, known as mutual aid such as taking or not taking of referrals. This meeting was chaired by Princess Anne Hospital head of Midwifery. On the morning call Princess Anne Hospital said they were Opel 2 and had a short fall across their service, from an expected 17 staff each shift of 4 midwives on the early/ 6 on the late and 4 on the night shift. As result they were not taking referrals but set a time for review later in the day.

Following our inspection the service leaders advised their actual midwifery staffing for 15 May 2023 had, on review, included 15 out of a possible 15 midwives; the MDAU had 3 midwives; induction of labour had 1 midwife, recovery had 1 midwife, 3 supernumerary midwives including the labour ward, operational coordinator and ward leads and in addition there were 3 supernumerary band 5/6 midwives working in the service.

In the midwifery-led birth centre at the morning safety huddle staff confirmed they had the correct staffing of 4 on shift for the early with 4 women or birthing people postnatal and 2 women or birthing people in labour after a busy shift the night before. However, later in the day they did not know how well the night shift was going to be covered but staff felt confident it would be addressed in time. Staff said generally in the daytime there would be 1 band 7 supernumerary, 2 midwives and 1 maternity support worker plus 1 to 2 supernumerary students. Staff said they did get breaks. We noted, however, there were not always 2 midwives at night, contrary to the service policy.

In triage the department had no planned dedicated staffing between 2.30am to 8.30am daily, when the service was covered by labour suite staff only. There was always a 24-hour onsite operational coordinator (band 7). On the day of inspection at 7.45am there were no women or birthing people in triage; the triage call system had 4 patients listed, 3 yet to come in and 1 who had already arrived the previous night and went straight to labour ward. At 8.30am as per rota 2 midwives arrived for the day shift.

The service had low vacancy rates, turnover rates, sickness rates and high use of bank midwives. Records showed that from December 2022 to May 2023 on average the service had a 13 WTE shortfall of midwives (6.2%), and a 3 WTE shortfall of MSWs (3%) per month. Sickness rate records showed from December 2022 to May 2022 was low at 3% for MSWs and averaged 13 (6%) for midwives per month. Staff told us they were normally able to cover shifts themselves through bank shifts in addition to their usual work schedule.

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. Records showed that there were 63 red flag incidents from November 2022 to April 2023, with 33 reports of delays for induction and beginning the process.

Leaders had full oversight of staffing. To support the national staffing acuity tool, the maternity service developed a systematic process for workforce planning in the form of a monthly dashboard. The live data reflected total staff unavailability to include vacancy rates, sickness ratios, maternity leave, and study time, all of which were compared alongside the budgeted versus actual staffing establishment overall.

There was a supernumerary shift coordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Staff told us there was always a supernumerary shift coordinator in labour ward and a supernumerary operations coordinator covering the whole service.

The operations coordinator had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

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 when they had time to do so.

Managers supported some staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The team included one band 7 practice development lead midwife supported by 3 band 6 midwives. Managers monitored appraisal rates and records showed that 56% of staff had an appraisal, while 44% were overdue.

Managers made sure staff received any specialist training for their role. The service had band 7 specialist midwives for the following, diabetes, immunisation, bereavement, infant feeding, safeguarding, public health, antenatal screening, fetal medicine and fetal surveillance. Each specialist lead delivered training specialist to their role and supported staff to make evidence based decisions about care and treatment.

Medical staffing

Maternity

The service had enough medical staff with the right qualifications, skills and experience, although not all junior medical staff had undertaken required training. 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 low vacancy, 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 standard operating procedure named 'Employment of agency locum doctors' which was implemented in May 2022. The SOP included a vetting checklist to ensure that locums had produced their General Medical Council (GMS) registration and could communicate effectively in English. The document also checked their competency levels. On arrival to the service locums received a full induction and orientation of the maternity department.

The service always had a consultant on call during evenings and weekends. The service had 8.7 whole time equivalent (WTE) obstetric consultants and 11 combined obstetric and gynaecology consultants. Consultants were on site from 8.30am until 5pm every night and on Wednesdays and Thursdays consultants remained on-site until 9pm. During nights, 8.30pm to 8.30am, consultant cover was off site and they could be called remotely to assess patients.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service used on site registrar cover around the clock. The service employed 6.7 WTE senior registrars, where there was a shortfall of 0.3 WTE and 9.25 WTE junior registrars with no shortfall.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Records showed that 76.5% of medical staff had started their online appraisal and another almost 15% were due to start this process. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

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

Women and birthing people's notes were comprehensive and all staff could access them easily. The patient care record was on a secure electronic patient record system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. We reviewed 8 records and found records were clear and complete.

Service managers completed clinical records audits. The digital team audited data completeness monthly to highlight missing fields to the relevant member of staff. The most recent audit January 2023 to April 2023 looked at 20 care records, which showed examples of gaps in record keeping. For example, 1 set of notes lacked depth to the clinical narrative, the relevant fields were completed for patient care. Five of the caesarean births did not have the perineal tear tab completed, and there was ongoing learning and education around using the electronic patient care record, 100% had had the birth notification sent, which is the most important field.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. This was because the electronic records system linked to other trusts using the same system. All NHS trusts in the region used the same electronic system for maternity services. Women and birthing people accessed their own electronic records using an online or mobile app. If a woman or birthing person did not have access to an electronic device staff could print records for them.

Records were stored securely. Staff were issued with individual passwords to access care records and locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service conducted 28 medicines training sessions per year and doctors using the electronic prescribing systems completed training before being provided access to the system. Medicines recorded on the digital systems for the 10 sets of records we looked at were fully completed, accurate and up-to-date. The service expected all new doctors to pass the medication safety assessment and if they failed the test they were offered supervision until they re-sat the examination.

Midwives completed medicines management training which included a medicine management competency test on administration of Patient Group Directive (PGD) medication. Records showed the 91.4 % of midwives had completed the training and 75% had passed the test first time. 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 rooms where the medicines were stored were 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 take action 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. Staff on the wards completed 4 medicine rounds a day and checked patient details and electronic prescribing charts prior to administration.

Staff learned from safety alerts and incidents to improve practice. Service leaders issued 'theme of the week' newsletters which reported on current safety alerts and practice improvements.

Incidents

Maternity

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 patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 6 incidents reported between January to April 2023 and found them to be reported correctly.

The service had not reported any 'never' events in the last 12 months.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Moderate and serious incidents were reported to the Board level maternity safety champions and the Local Maternity and Neonatal System (LMNS) monthly. Data from the maternity dashboard showed that from January 2023 to April 2023 there were 3 incidents reported to the Health and Safety Investigation Branch (HSIB), and 9 moderate incidents (meaning patients required follow up care and treatment due to the adverse incident).

Staff reported serious incidents clearly and in line with trust policy. The trust had 5 serious incidents that required managers to complete a rapid review to identify immediate actions or learning. Records showed that in May 2023 the service had 2 outstanding incidents over 60 days.

The service's Perinatal Mortality Review Group met monthly and included the risk and governance lead, the consultant midwife, the consultant pathologist, and the bereavement midwife. The group reviewed incidents to make sure they identified in gaps in care and created reports for the Board.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities and these were recorded in the case review report. We looked at 3 of these reports and saw where women or birthing people's social or mental health needs impacted on their pregnancy experience, this was recorded. None of the 3 reports recorded risks in relation to the woman or birthing person's ethnicity.

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

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

Serious case review reports showed other agencies involved in the review and external agencies that the service needed to report the outcome of the review to. The reviews also identified immediate actions and support for staff groups involved in the incident. However, minutes of meetings, such as Maternity Safety Champions Meeting and the Women

and Newborn Governance Group Meeting, only showed statistical information about serious incidents. Board reports included a patient story item, although this was not specific to maternity, so they could reflect on the experience of patients and understand what the trust could do better. The lack of detail about serious incidents did not provide assurance that more senior staff in the service were familiar with and understood all aspects of the incidents.

Managers debriefed and supported staff after any serious incident. Staff told us that managers spoke to and supported them after any serious incident. We saw, however, that this could take some time if the different parties involved in the incident were busy elsewhere and could not return immediately. Staff on one ward were still waiting for a debrief a few hours after an incident on the day of our visit.

Is the service well-led?

Good 

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

Leadership

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Maternity services at Princess Anne Hospital were managed as part of the Division C directorate. There had been a lot of change in the maternity service leadership due to restructuring and the maternity services were led by a team of 5 people. This consisted of the director of midwifery, the interim divisional director of operations, the divisional clinical director, the care group clinical lead and a consultant obstetrician. They had a clear understanding of the challenges to quality and sustainability within the service and the plans to manage them, which were shared with staff.

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 supported by their line managers, ward managers and matrons. The 2022 NHS staff survey also indicated staff felt they were valued, listened to, and supported by managers, although these figures were slightly less than in the 2021 survey. 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.

Maternity safety champions and non-executive directors supported the service. The director of midwifery met with the Board maternity safety champion regularly. Both the maternity Board safety champion and the director of midwifery were aware of issues relating to the quality and safety of the service and were advocates for the service at Board level. We reviewed minutes of the safety champion walk abouts for September to December 2022. These showed a clear structure which covered relevant safety areas.

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

Vision and Strategy

Maternity

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 trust had developed a 5 year strategic plan that started in 2021 and identified 5 key themes, which were aligned to their vision and values. The maternity service had its own vision and improvement plan, also based on the trust's vision and strategic plan. One of the key national drivers for maternity services was to continue improving outcomes for women, birthing people and babies by reducing maternal and neonatal deaths and brain injury from birth. The service's improvement plan identified delivery of this key national driver required "local transformation, where providers, Commissioners and service users work together as part of a Local Maternity and Neonatal System (LMNS)."

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 integrate them and monitor progress. University Hospital Southampton NHS Foundation Trust formed partnerships with other local trusts to collaborate on improving healthcare provision. This formed one of the priorities in the trust's strategy with the aim to create a high-quality integrated care system for the Local Maternity and Neonatal System (LMNS).

During our inspection we saw how the service worked effectively to ensure the safe care of women, birthing people and babies, with other trusts that were part of the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) LMNS. They had daily contact with other trusts in the LMNS to look at each trust's status in regard to staffing and risk, and then to determine whether transfers of women, birthing people or babies was possible and what may be required to enable those transfers if needed. This worked well and showed a cohesive system that provided the safest care to as many women, birthing people and babies across the region as possible. Staff could explain this vision and understood the need for and value in sharing care across the wider LMNS area.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and planned to revise the vision and strategy to include these recommendations. There were 5 recommendations made, including recording the twice daily ward rounds, embedding standard operating procedures, engaging with the Maternity Voices Partnership and improving personalised care and support plans. Delivery of the service's Ockenden action plan was regularly mentioned as part of monitoring and governance processes, such as the Safety Champions Meeting minutes.

Culture

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

Staff we spoke with during our inspection visit felt respected, supported, and valued**.** They were positive about the hospital, its leadership team and felt able to speak to managers and leaders about difficult issues and when things went wrong. Staff told us they were happy at work and were supported by other staff.

Staff felt respected, supported, and valued**.** Staff were positive about the department and its managerial leadership team and felt able to speak to leaders about difficult issues and when things went wrong. However, the 2022 NHS staff survey showed satisfaction about this compared with the 2021 survey results was slightly reduced.

Maternity

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Partners were encouraged to stay with women and birthing people during labour and were also able to stay postnatally. Staff recognised this provided support for women or birthing people and helped form a close family bond. Dignity, caring and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. We saw that women and birthing people were spoken with respectfully and included in decisions about their care. Women and birthing people we spoke with told us staff were, "Very caring," and they, "Can't fault staff."

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, 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 trust had developed a community team of staff who visited and supported women and birthing people from ethnic minority and disadvantaged groups in their own homes throughout their maternity journey. This provided support during and following pregnancy for women and birthing people who may have greater difficulty accessing maternity services.

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.

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

Managers investigated complaints, 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.

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. These included Governance for Patient Safety within Maternity Services meetings, Executive Management Board meetings, and Women and Newborn Governance Group meetings. Meeting minutes show these were well attended and discussions included updates on how the service was performing in relation to national guidance and audits, the risk register for maternity and serious incident learning.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Governance Group meeting minutes showed guidance that needed to be reviewed was identified and where it was on the review and approval pathway.

We reviewed clinical guidance, including those for triage and reduced fetal movements, which were in date.

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

As part of the National Maternity and Perinatal Audit the trust looked at how many women and birthing people had been supported with written information or a conversation about reduced fetal movements. Data for Princess Anne Hospital showed staff recorded this in 100% of records between January and March 2023.

Outcomes for women and birthing people reported against national standards. These showed the service was higher than the national average for both third and fourth degree tears, and post partum haemorrhage (PPH) of more than 1500ml. Managers monitored outcomes on the maternity scorecard, which provided statistical information on a monthly basis. When these statistical figures were outside national standards, these were discussed at risk meetings to ensure appropriate actions were taken to improve. Data supplied by the trust showed effective fetal monitoring during labour was recorded 80% of the time. Managers and staff used the results to improve women and birthing people's outcomes. Staff developed a 'Current Audits and Quality Improvement Work' newsletter in April 2023 that showed the PPH audit had found 36% of notes were not fully completed with medicines given in the 3rd stage of labour, and that there was a 3rd stage drugs and PPH bundle for staff to use.

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. However, only category 2 caesarean sections were audited, which did not identify whether other category caesarean sections were completed within timeframes to comply with national guidelines. 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.

Staff completed an audit of completion of the Modified Early Obstetric Warning System (MEOWS), which is a set of clinical observations that provide a guide about how well the women or birthing person is. The audit identified that

these were correctly recorded 80% of the time, against a target of 75%, but that where these had not been completed properly staff had failed to record respiration rate. An action plan was developed to educate staff of the importance of completing respirations and to produce an example of the record for staff, and then to reaudit recording of MEOWS later in the year.

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. The service recorded risks on their risk register, which included maternity and medical staffing, theatre capacity, acuity within maternity services, insufficient space in induction of labour and maternity day assessment. Mitigating actions were identified and reasons for difficulties in increasing staffing numbers.

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

Information Management

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

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

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service had a digital midwife who was able to support staff to navigate the system at Princess Anne Hospital and who looked at data validation across the service. They were also able to pull data from the system to support the trust analysis of performance. The trust had a strategy to reduce the amount of paper records used and fully implement their electronic system.

The information systems were integrated and secure**.** The trust used a digital recording system, which staff in all areas of the service had access to. Staff were required to log in and out electronically before being able to see records.

Data or notifications were consistently submitted to external organisations as required. Staff made referrals to external organisations, such as the Healthcare Safety Investigation Branch (HSIB), following serious incidents.

Engagement

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

Leaders had a limited working relationship with the local Maternity Voices Partnership (MVP) in decisions about patient care, which was because it did not fully fit with their preferred programme for engagement. Despite this, staff did take part in meetings with the MVP and shared areas of concern and improvement, and upcoming plans with the MVP. The MVP chair had a named staff member in the trust who they spoke with regularly and were able to discuss any concerns with.

The service used their own mechanism for gathering patient feedback from women and birthing people. This included text messages a week after birth, family and friends paper feedback forms that were available in the service and given out on discharge, and feedback in the annual NHS Maternity Survey. Information from the trust shows these surveys identified an improvement in women and birthing people's postnatal experience, but some issues around communication and staffing. The NHS Maternity Survey for 2022 showed the service had significantly better scores in 6 areas and better scores in 3 areas, while 42 other questions were the same as the year before. The service had particularly good scores in mental health queries, treating women and birthing people with dignity and respect, involvement of the pregnant person in induction of labour decisions, decisions about how to feed their baby and postnatal care.

In response to the findings of the Ockenden report, the trust had implemented a Maternity Voices Partnership action plan, which included quarterly meetings, building relationships with local community groups, and holding listening events. Meeting minutes showed the MVP had started work on developing promotion of events to targeted groups, they had relayed feedback from women and birthing people they had spoken to, identified concerns that needed to be addressed immediately and offers of support to ensure information was inclusive of all gender groups.

Leaders engaged with other trusts in the region on a daily basis to discuss staffing levels and bed availability for high risk women, birthing people and babies. Staff also had a follow up call at 4pm and regrouped to reassess the situation before night shift started. They were able to call emergency meetings and had access to a WhatsApp group where they could share issues with the wider LMNS.

The service made available interpreting services for women and birthing people and collected data on ethnicity. Staff had access to Language Line, a telephone interpreting service.

Leaders understood the needs of the local population. The service had identified local areas of social deprivation, close knit ethnic minority communities and the difficulties women and birthing people sometimes had in accessing maternity care early. They had developed specific teams who worked solely in these areas to build relationships and provide access to services.

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.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Staff were involved in ongoing monitoring of both national programmes, such as Saving Babies Lives, and quality improvement programmes specific to the service. This included a project looking at the reasons for readmissions to the maternity service and showed the majority reason for this was possible sepsis or wound infection.

Another programme looked at maternity and neonatal improvement outcomes to reduce unwarranted variation and provide a high quality healthcare experience. As a way of ensuring babies needing admission to the neonatal unit were able to have a cuddle when they were born, staff help this to happen even if the baby is on a ventilator. Staff also

developed an innovative method of providing respiratory support using existing equipment while the umbilical cord is still attached, to improve rates of optimum cord management. This is delayed clamping of a baby's umbilical cord after birth. It helps prevent a sudden drop in the baby's blood pressure by allowing extra blood from the placenta to replace the blood that flows into the baby's lungs when they take their first breaths.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

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

Outstanding practice

We found the following outstanding practice:

- The telephone triage line provided a dedicated phone line for access to a midwife 24 hours a day for help and advice and referral to the appropriate maternity service. The referral service was based in a local ambulance hub, staffed by 3 midwives at all times and ensured a speedy response to all callers, while preventing the need for a phone service at Princess Anne. The referral monitor included essential details and linked to the electronic records system.
- The service worked with the LMNS to develop and implement a joint maternity and neonatal process to ensure women, birthing people and babies received the most appropriate care at the most appropriate service. They linked with other LMNS services at least once a day to look at staffing and capacity issues at each service so women, birthing people and babies that needed more specialist care, or who could be cared for in a different setting were able to receive this.

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.

Action the trust MUST take to improve:

Maternity

- The trust must ensure medical staff are up to date with all training, including mandatory, safeguarding to level 2, skills and drills training modules. Regulation 12(1)(2) (c)
- The trust must ensure the security of the unit at all times. Regulation 12 (1) (2) (a) (d)
- The trust must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)

Action the trust SHOULD take to improve:

Princess Anne Hospital

Maternity

- The trust should continue to monitor and review infection control practices by staff to ensure poor practice is eliminated.
- The trust should consider investment in the estate to help modernise the service and experience of the patients and staff.
- The trust should consider review of training for medical staff for level 3 safeguarding training in line with current guidance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, an inspection manager, and 3 specialist advisors (2 midwives and an obstetrician). The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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