Isle of Wight NHS Trust

St Mary's Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at St Mary's Hospital

Good ➔➔

The Isle of Wight NHS Trust is an integrated trust that includes acute, ambulance, community and mental health services. Services are provided to a population of approximately 140,000 people living on the island. The population increases to over 230,000 during the summer holiday and festival seasons. St Mary's Hospital in Newport is the trust's main base for delivering acute services for the Island's population. The maternity unit at the hospital comprises of a delivery suite, birthing pools, midwifery unit, a dedicated operating theatre, recovery area, antenatal and postnatal wards and a triage area. This is alongside the maternity clinics provided in an outpatients setting. From January to December 2021, there were 944 recorded births at the hospital.

We inspected the maternity service at St Mary's Hospital, Isle of Wight NHS Trust 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.

During this inspection we spoke with 21 members of staff, both during the inspection and post-inspection. We spoke with the local Maternity Voice Partnership (MVP) lead, reviewed 7 maternity care records, spoke with and received feedback from 12 current and former women and partners and visited all areas of the maternity unit.

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.

How we carried out the inspection

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:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. 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 and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women 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:

- Staff were not monitoring triage times. Staff were unaware of any audit of triage waiting times and reviews.
- The service used systems and processes to safely prescribe, administer, record and store medicines. However, the recording of medicine administration was not always clear.

Is the service safe?

Good ↑

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. At the time of inspection, the overall mandatory training completion rate was 90% on a rolling 12-month cycle. This was against a trust target of 90%. During the inspection, senior staff told us a new training subject relating to domestic violence had just been added in recent days to the overall mandatory training suite of subjects. We were told that all staff would be completing this new training as soon as practically possible.

The mandatory training was comprehensive and met the needs of women and staff.

Core skills training was delivered online and included but was no limited to, conflict resolution, fire safety, infection and prevention control, information governance and preventing radicalisation.

Staff completed Practical Obstetric Multi Professional Training (PROMPT), which was a standardised course covering practical training scenarios such as management of obstetric emergencies. The service had an overall completion rate of

98%. Theatre staff achieved 96%, 94% compliance for anaesthetists, 100% for obstetricians, 100% for maternity staff and 100% compliance rate for members of the management team. This was against a trust compliance rate of 90%. Staff spoke highly of the delivery of PROMPT training and told inspectors they enjoyed the teaching sessions which provided opportunity for questions and learning from peers.

Newborn Basic Life Support (NBLS) training for midwifery staff was 91% overall compliance at time of inspection, this was against a trust target of 90%. NBLS was covered in PROMPT for medical staff where overall compliance was 96%.

Clinical staff received training to interpret and categorise cardiotocograph (CTG) results. Training was delivered annually and included an assessment. Evidence provided by the hospital showed, at the time of inspection, midwifery staff were 98% compliant with the training and 90% compliant for medical staff. The overall compliance rate was 97%. This was against a trust target of 90% compliance.

Practice development midwives (PDMs) would inform managers when mandatory training was due. Managers then promoted staff to complete training. Staff told us; managers were supportive if protected time to complete training was needed.

All staff were trained in dealing with families experiencing a loss, and there were midwives with specific interest in this area, whom could be called upon for guidance and support.

Safeguarding

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

All staff received safeguarding children level 3 training. Overall completion of this training was 99%. Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Safeguarding training included a set of learning outcomes to ensure staff were well informed and equipped with the knowledge and understanding of any potential safeguarding concerns. Learning outcomes included how to escalate concerns, identification of domestic abuse, parenting diaries and substance misuse, amongst others.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding lead for the service was visible and staff reported this person being approachable if they had any concerns or queries. The safeguarding lead told us they helped support staff to have difficult conversations with women and partners and supported staff to fill out safeguarding referrals and meeting reports such as case conference. The lead emphasised the responsibility of safeguarding fell to individual staff but they were there in a supportive capacity.

The safeguarding lead told us they had good working relationships with social services, the police, local communities and drug and alcohol support services.

Maternity

Staff followed the baby abduction policy and undertook baby abduction drills. The latest baby abduction skills drill was carried out in October 2022. Staff which could not attend were invited along to another session to ensure everyone had undertaken a practice drill. Staff told us the latest drill had gone well and been successful. One of the only learning points identified was ensuring there wasn't an overcrowding of staff in the room when an emergency happens. Staff spoke positively of the drill exercises and found all learning was essential to their role.

The service had not recorded any security breaches.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There was evidence staff completed cleaning and room preparation checks in accordance with trust policy. There were cleaning schedules for each room including toilets and bathrooms across the maternity unit. Staff on the midwifery unit were clear which rooms were clean and ready for use.

The service carried out cleaning standards audits in each area of the maternity unit. An October 2022 audit showed the labour suite was 96% compliant with cleaning standards set by the trust. The result showed 95% compliance for the obstetric and outpatients department and the main maternity ward scored 97% compliance.

Trust data showed the maternity unit scored 100% compliance in the October 2022 hand hygiene audit. The September 2022 audit also showed 100% compliance. This audit was set against standards such as, before and after patient touching, after blood/body fluid exposure, and physical contact with patients.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. The unit used green 'I am clean' stickers to indicate what equipment had been cleaned and when.

Women who were booked for elective caesarean section (c-section) were screened for MRSA (methicillin-resistant Staphylococcus aureus) during their pre-operative assessment appointment. This was evident in the records reviewed.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using correct PPE when treating women and babies.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas in the maternity areas and hospital entrance for staff, patients, and visitors to use. We observed multidisciplinary staff applying hand sanitising gel when they entered clinical areas and washing their hands between patient contact.

Staff carried out the decontamination of surgical instruments in theatres accordance with national guidance.

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.

Maternity

The midwifery unit was open 24 hours a day. It included a day assessment unit and an emergency assessment service known as triage. Women attended with planned and unplanned appointments. They also attended for assessments to determine if they were in established labour. There was a small, dedicated waiting area for women and their partners and women also waited outside the clinical area but in view of the receptionist. Staff told us they did not have many women waiting for an assessment at one time and did not feel as if there was unmanaged crowding in the corridor. During our inspection, we observed only one woman waiting in the dedicated waiting area to be assessed in the triage room.

The unit had its own operating theatre for planned and emergency caesarean sections and other obstetric surgical procedures. We were told there were occasions when theatres were in use when a woman needed an emergency caesarean section. However, staff told us they could utilise the main theatre area if required, however, this was rare and staff felt the theatre area in the midwifery unit was sufficient to meet patient's needs. Staff told us they had used the main theatres for a caesarean section once in the past year. The trust did not provide any evidence on how many times the main theatres had been utilised. The service had use of an anaesthetic room and recovery area. We were not aware of any drills staff undertook regarding the emergency transfer of women to an operating theatre outside of the main maternity unit.

The unit had a specific suite for women and families who had experienced a baby loss. The area included a dedicated bereavement room in a quieter area, with a separate entrance. It was located away from labour rooms so that it offered families a private and comfortable space to grieve the loss of their baby. The area needed refurbishment and funding had been secured for works to commence in 2023.

Equipment was fit for purpose and adhered to safety standards. Daily checks were completed for equipment, including emergency equipment, across the maternity unit.

Across the maternity unit we found items of equipment such as mattress, blood pressure machine, CTG machine, suction units, mattress, weighing scale, circulation machine had been serviced and/or portable appliance tested.

The layout of the unit supported the volume of women who accessed the service. Areas were private and there were rooms for partners and relatives to sit if required.

Staff disposed of clinical waste safely. Colour coded clinical waste and sharps bins were available and accessible in all areas. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. However, staff did not always effectively monitor the waiting times for triage.

We reviewed 7 maternity care records. The lead clinician was confirmed in all of them. Risk factors were highlighted. For example, women with a high body mass index, living in a deprived area, or comorbidities. Women were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

Carbon monoxide screening was performed in each set of notes reviewed in line with best practice guidance.

Staff monitored the baby's growth, and accurately plotted this. Staff identified babies that were not meeting their growth potential, as they would be at higher risk of complications. Women were screened for safeguarding concerns and staff used the information to plan care and involve the right staff.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. The use of this was through the electronic software system the unit was using. Subsequent observations were also recorded on a chart. This meant staff could identify a trend and escalate where appropriate. The Trust told us this system had been planned for introduction during the period of our inspection, and that the implementation went ahead according to their set timetable. Staff felt the new triage system would come with added benefits, such as easier to navigate functions as well as being easier to extract data for learning and service improvement. The trust told us this system would be fully implemented imminently after our inspection.

Staff ensured women understood the importance of vitamin D supplementation and monitoring their baby's movements from 25 weeks of pregnancy.

Women who chose to give birth outside of guidelines were supported. They were offered an appointment with a consultant obstetrician and/or an appointment with a consultant midwife. The consultant midwife discussed the woman's decision, and they agreed a birth plan. The aim was to support their choice and ensure everything was planned to ensure the birth was as safe as possible. Midwives told us the teams worked together well to support informed choice. Midwives felt well informed and well supported in these situations

Staff shared key information to keep women safe when handing over their care to others. They used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members. They discussed key information about women's pregnancy, labour or postnatal information. This also included information of concern. For example, safeguarding concerns, and information about their wellbeing and support from partners and family.

Safety huddles took place in each ward or area and included necessary information to keep women and babies safe. Managers had an overview of staffing and acuity across the unit.

We reviewed four cardiotocographs (CTGs). All four had fresh eyes completed hourly. Fresh eyes mean a midwife or obstetrician reviews the CTG every hour with a colleague, to reinforce good practice and help with decision making.

In the triage area staff told us women never had long to wait to be reviewed. Staff told us unplanned care took priority over women who had routine appointments. No member of staff we spoke with felt women were left waiting long to be seen. However, the was no system to audit the triage area for its effectiveness in seeing women promptly for assessment.

The unit had a dedicated telephone line for patients to call if they had any concerns or queries. The phone-line was put through to a member of triage staff to assess and advise the women accordingly. Notes from these conversations were recorded in the women's care record.

Midwifery Staffing

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

Maternity

The service had enough nursing and midwifery staff to keep women and babies safe. The service was over the funded establishment of midwives at the time of our inspection by 1 WTE. According to data supplied by the trust, there were currently 57.6 whole time equivalent (WTE) midwives as of October 2022.

In order to aid staff retention, the trust was in the process of implementing a number of initiatives, including a band 7 midwife focussed on recruitment and retention with particular focus on supporting student midwives, monthly midwifery listening events to encourage speaking up, monthly safety walk rounds by safety champions to talk to teams on shift and monthly newsletters to update colleagues on progress around recruitment.

The sickness rate for healthcare assistants in maternity at the trust increased from 2.7% in December 2021, to 9.8% in June 2022. The trust told us this was due to long term sickness and because of the low numbers of staff employed, 2 members of staff being absent had a bigger affect on the overall sickness rate.

The trust sickness target was 3%; data supplied by the trust showed in September 2022 the sickness rate for registered midwives was 1.6% and in October 2022, the sickness rate was recorded as 2.36%.

The service used Birthrate Plus to monitor acuity and calculating midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives (RCM). Staffing levels were reviewed at daily handovers and huddles and any staff shortages were escalated to the deputy head of midwifery, labour ward coordinators, flow midwife and matrons in charge. Information supplied by the trust showed the latest Birthrate Plus compliance level was 88% for the unit; a compliance rate of over 85% is considered 'good' using the Birthrate Plus tool.

A review of a bi-annual staffing report from January to June 2022, showed the trust had been successful in a recruitment campaign and was expecting 3 whole time equivalent (WTE) international midwives commencing employment in November 2022, 4WTE preceptorship midwives starting in September 2022 and 1WTE nurse on a midwifery conversion course commencing in 2023.

The service made sure staff were competent for their roles. PDMs were responsible for ensuring any concerns with staff competence were effectively escalated to their line manager. PDMs worked with line managers to support staff when competence issues were identified.

Safe staffing in maternity was regularly reported to the trust board. The trust had completed a recruitment and retention plan and had a workforce strategy in place. This included a review of all maternity staff establishment, roles and banding. This was aligned to the Birthrate Plus recommendations for midwife to support worker ratio, to improve the quality of experience for women and families.

Senior staff told us they did not use agency staff, shifts were covered with their own midwives, supported by community midwives when required.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data supplied by the trust showed appraisals completed for maternity staff were 93% in October 2022. This equated to 87 appraisals being completed. The trust target was 90%.

There was a preceptorship programme for newly qualified midwives. The programme adopted a blended learning approach. It included study days, electronic learning modules and reflective sessions. Newly qualified midwives we spoke with talked highly of the preceptorship programme, telling us they felt well supported, had good peer relationships and staff took the time to explain things.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The clinical lead took responsibility for ensuring other medical staff were up to date on training, changes to best practice guidance and supervised practice.

Data supplied by the trust showed that the establishment included 6 WTE consultant obstetricians. Five consultants were in post at the time of our inspection. There were 7 middle grade doctors employed against a funded target of 7. Information at the time of inspection showed all grades were either at full or over establishment.

Staff told us they were expecting one more consultant to be joining in November 2022, who was coming from overseas. Staff told us it had been a struggle recruiting to the consultant post, as the job advert had been out for over 12 months with little interest. Staff told us they would be concerned if medical staff were to leave, as replacing them was challenging partly due to the geographical location of being on a small island. Consultant obstetricians were also trained gynaecologists, so covered both specialists within the hospital.

The unit was supported by other medical staff who were on rotation throughout the department. For example, we spoke with one member of medical staff who was undertaking GP training and was assigned to work in the department to gain experience in obstetrics. This member of staff told us they felt supported by their peers and superiors and the unit offered lots of opportunity for learning.

The first Ockenden review of maternity services in December 2020 had an immediate and essential action stipulating there must be twice daily (day and night through the seven-day week) consultant led and multidisciplinary ward rounds on labour ward. The trust had twice daily ward rounds in place at 0830 and 1600, with a consultant attending virtually at 2030. The trust told us significant financial investment and funding would be required to implement a consultant being present at the 2030 ward round. Senior staff told us they did not always feel this approach was required but did acknowledge the Ockenden essential actions should be treated seriously, however, they did not feel a one-size fits all approach worked best for their unit. The Director of Midwifery (DOM) was working with NHS partners to ensure this Ockenden action was tailored appropriately for the service.

The department had a dedicated anaesthetist 24 hours a day, seven days a week to cover labour ward. In the event of a second anaesthetist being required, the duty on call anaesthetist would be called to attend. The trust staffing policy had been updated to reflect the anaesthetic Ockenden recommendations.

The trust provided evidence that the current neonatal medical workforce complied with the British Association of Perinatal Medicine (BAMPM) national standards of junior medical staffing. A resident Tier 1 practitioner was dedicated to the neonatal service in daytime hours on weekdays as per the recommendations.

Maternity

The maternity service multidisciplinary team (MDT) worked together with external multi professionals such as social workers, GPs and health visitors and hospitals to improve patient care and outcomes. Doctors, midwives, midwifery support workers, safeguarding midwives, perinatal mental health midwives and other healthcare professionals supported each other and were involved in assessing, planning and delivering women's care and treatment.

Staff held regular and effective multidisciplinary meetings to discuss and improve the provision of care to women using the service. Daily safety huddles, ward rounds and handover meetings took place to update staff on plans for women and babies.

MDT staff spoke highly of each other and the focus on collaborative care to improve care and patient outcomes.

Records

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

Women's care records were comprehensive, and all staff could access them easily. The service used a nationally recognised software programme to record information relevant to women. We reviewed 7 records for women at different stages of the maternity pathway and found records were comprehensive, all risk assessments and clinical assessment were documented such as VTE, fetal movement, high or low risk pregnancy, safeguarding questions and MEOWS.

Information supplied by the trust showed a number of audits being undertaken monthly, bi-monthly and annually relating to patient records. Audits included documentation of VTE, MEOWS, fluid balance and Co2 monitoring. A review of the latest audits showed full compliance against agreed standards set by the trust.

Another audit carried out by the trust was whether blood group, antibody status, anti-D given within 72 hours and recording of administration were documented clearly within patient records. A review of these audits, carried out annually, showed the last audit in March 2022 was compliant with the internal standard operating procedure (SOP) guidelines.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, recording of administration did not follow the trusts prescription chart format.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed systems and processes to prescribe, administer and store medicines safely. They received mandatory training in medicine management every year.

Midwives were recording information relating to the prescribing and administration of drugs on a paper-based document. However, this form did not contain enough columns, meaning staff were writing information outside of the columns, which made it difficult to interpret what drugs had been given and when. We fed this back to the trust at the end of our inspection and were informed that shortly after our visit, staff had implemented a new and updated form to ensure accurate recording could take place. Drug administration was also recorded on the electronic system.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. We observed a situation where a staff member took the time to explain medication side effects to a woman and their partner.

Records for checking controlled drugs demonstrated that the medicine policy was followed. Records showed two staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Emergency trolleys and equipment throughout the unit were locked and sealed. These trolleys and equipment contained intravenous fluid and drugs to use in emergencies. We saw daily checks had been completed on each of these trolleys.

Fridge temperatures were checked daily in all clinical areas. This was to ensure the fridge temperature were maintained between a minimum and maximum recommended temperature. Daily checklists were updated and signed by the person checking.

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 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. There was a clear process which all staff we spoke with understood and followed. The trust used an electronic reporting system which all grades of staff had access to. Everyone understood their responsibility to report all incidents they felt could affect safety.

Managers debriefed and supported staff after any serious incident. Staff told us they felt well supported by colleagues, managers and the wider team when they were involved in an incident.

Staff received feedback following incident investigations and themes and learning from incidents were shared. There was a staff update board in all clinical areas. This included a variety of clinical information to update staff. For example, themes from incidents, learning identified, and good practice was highlighted. Staff also got updates via other means such as handover, emails, message of the day and week and from their line manager.

Staff understood the duty of candour (DoC). They monitored their compliance to DoC through audit and results showed they were open and transparent and gave women and families a full explanation when things went wrong. They assessed the application of the DoC against all incidents and maintained and monitored compliance through their maternity dashboard. Women were involved in investigations and had a point of contact, so they had continuity and support throughout the process.

Data supplied by the trust showed all reported incidents in the previous 12 months, their actions and recommendations and whether the incident had been investigated in a timely way and in accordance with trust policy. Incidents were

clinical and non-clinical in nature and included incidences of shoulder dystocia, tears, baby readmission and an incident relating to poor communication as a result of a language barrier. In each of these incidents, we saw actions the trust had taken to minimise, reduce or eliminate reoccurrence, this included providing workshops and learning sessions to staff, bulletins, and newsletters to highlight specific issues and changes to policy and practice.

The service had not reported any never events in the past 12 months. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Is the service well-led?

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

The senior leadership team was formed of a director of midwifery, two deputy heads of midwifery, a consultant midwife and a clinical lead. There was also a business support manager who supported ward clerks, receptionists and housekeepers.

There was a clearly defined management and leadership structure in place. The director of midwifery was overseen by the director of nursing, midwifery and allied health professionals (AHP's). This person was also designated executive maternity safety champion, above them was the Chief Executive Officer (CEO).

The trust also had a non-executive director (NED) with responsibility as maternity safety champion. The purpose of this role was to highlight issues and concerns relating to maternity to the board and to formulate an understanding of the issues facing maternity on a strategic level, with some oversight nationally as well as issues specific to the trust. We spoke with the NED who appeared well-informed of the issues in the service, particularly recruitment and retention and ensuring the voices of women were promoted. Evidence from recent board meeting minutes showed a healthy discussion regarding topics specific to the area of maternity.

We were told of joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

Staff told us senior managers were visible and available. They completed daily walk-rounds of clinical areas. There were five safety champions for maternity services. Managers also completed regular walk arounds. Staff found them approachable, and keen to hear their views and experiences, to drive improvement.

The director of midwifery attended board meetings. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies and compliance with legislation and the implications on finances.

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.

There was a trust wide strategy for nursing and midwifery for 2022 – 2025. The vision was to empower nursing and midwifery excellence and strive to support women, birthing people, and their families by ensuring safe, effective, and personalised care is provided. The strategy was centred around five core strategic objectives, people, performance, partnerships and place.

The development of the strategy involved collaboration with stakeholders within the trust, local maternity network system (LMNS) region and the wider midwifery network. The service had liaised with staff and the maternity voice partnership (MVP) in developing this strategy.

Implementation of the plan was reported to the nursing and midwifery executive committee. The director of midwifery would provide a clear link to the clinical group executive team. Post inspection, the trust told us the planned implementation date was end of November 2022.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

We spoke to staff across most grades and disciplines. Staff told us they were proud to work for the trust. Staff also told us the multidisciplinary teams worked closely, respected each other, and were united to improve outcomes for women and their babies. The staff were overwhelming happy in their role and working for this trust, related to the support received from leaders and the staffing levels obtained. This had promoted a calm and caring culture across the maternity service.

The trust had a freedom to speak up guardian. Staff told us they knew who their freedom to speak up guardian was, and they would be confident to raise a concern with their managers.

Data supplied by the trust showed there had been 3 formal complaints raised in 2022, so far. There were currently no identifiable themes or trends. Each complaint had been investigated and a response provided. One of the complaints was yet to be finalised.

Staff told us the service was open and transparent and there was a no blame culture when incidents happened, and the team supported each other. Staff received debriefs and support from their managers following serious incidents.

New members of staff, junior doctors and student midwives told us they were made to feel welcome, and everyone was willing to help.

The service promoted equality and diversity in daily work and provided opportunities for career development. All staff received training in equality and diversity.

The service had monthly team meetings in place to promote staff wellbeing, this included topics such as psychological safety, wellbeing, culture of civility and respect.

Governance

Maternity

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.

Information was captured and used to monitor the quality of the service provided. The maternity dashboard captured information on workforce, maternity morbidity, perinatal morbidity and mortality, readmissions, maternity safety, test endorsement and public health data.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas and trust website.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clearly defined reporting avenues. Incidents, risks, performance, guidelines, audits and user experience were discussed at governance meetings. These fed into divisional meetings which then escalated to trust wide committees through to the subcommittees of the board.

The maternity service sought reassurance through various governance meetings in the service, divisional meetings and trust board meetings. This included maternity quality governance meetings, senior team meetings, board meetings and serious incident meetings. Governance meetings were chaired by the most appropriate person, with clinical leads or executive leads attending as necessary. We reviewed a selection of governance meeting minutes and found them to be detailed and clear. Meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Outcome of governance meetings and service dashboard were shared with staff through emails, newsletters and posters.

Maternity services had a quality improvement project (QIP), programme for 2022-2023. This included approved quality projects, national and local audits and service evaluations. They participated in national audits which included national maternity and perinatal audit and MBBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) audit.

National guidance advocates consideration of assessment by telephone triage, provided by a dedicated triage midwife for all women (NICE, 2017). Trust senior leaders told us there was a plan to centralise the telephone triage service which would incorporate the role of a dedicated midwife 24 hours per day to respond to telephone triage queries across all Hampshire maternity services This was due to be implemented in the first half of 2023.

Staff were recording but not monitoring triage times as the time of arrival and time of triage were not reviewed the to identify opportunities for improvement. Staff were unaware of any audit of triage waiting times and reviews. This mean the trust had not reviewed if women were seen and treated according to their clinical urgency and need.

A review of recent trust board meeting minutes reflected a check and challenge on maternity and neonatal services from the non-executive safety champion for maternity services.

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.

A risk register and patient safety tracker was used to identify and manage risks to the service. These documents included a description of each incident or risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk or incident materialising, it's possible impact and the review date were also included. The risk register included information relating to estates and facilities issues and a requirement for additional equipment.

Maternity performance measures were reported using the maternity dashboard, which was RAG rated with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The trust had not been identified as an outlier in any metric measured.

Mandatory training was concerned with minimising risk, promoting quality and ensuring the trust met external frameworks; for example, the Ockenden (2019, 2022) Immediate and Essential Safety Actions and professional registration for midwives to ensure the trust complied with statutory requirements.

The service used the maternity dashboard and a systematic programme of clinical and internal audit, to monitor risks and quality to identify where action should be taken.

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.

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

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

The service engaged well with the stakeholders and was actively involved with their local Maternity System group (LMS). A representative from the trust attended the meetings. The meeting was attended by other trusts and clinical commissioning groups as well as any other relevant stakeholders such as local GPs, NHS England and local authority representatives.

The maternity service had an active and functioning Maternity Voices Partnership (MVP) which met regularly and was involved in the service planning and delivery, and review and development of policies, guidelines, update of website,

creation of information leaflets and videos for the public on the trust website. The service had engaged with women and the public on the development of their maternity strategy. Staff reported good relationship with their MVP. The service had also worked with the MVP to encourage diverse membership, specific cultural survey events run by the MVP in the family centres and libraries, and meetings with local groups faith leaders.

There were systems in place to engage with staff. The senior leadership team told us the wellbeing of all staff was prioritised by senior leaders.

The MVP worked with maternity services to bridge any gaps with women that could be harder to reach. They used social media platforms to connect with women, raise awareness, and act as their advocate. The trust valued their partnership working with the MVP and monitored their engagement.

The trust undertook a Friends and Family Test (FTT) across the maternity unit. This is a way of collecting feedback from users of the service. In the FTT summary for October 2022, 27 responses were received across antenatal services, labour and postnatal ward. Twenty-four of these responses marked the service as 'very good' and 3 responded with 'good'.

The service worked with external organisations and monitored the number of requests for action from CQC, NHS England and Healthcare Safety Investigation Branch (HSIB). Any requests were monitored through the maternity dashboard.

The maternity strategy considered the views and opinions of the Black and Minority Ethnic (BAME) community. The MVP chair told us they were working closely and successfully with staff from the trust and external agencies to reinforce and refresh their communication to community groups. There was a common goal of making information available to hard to reach communities. This also linked in with the current Equity of Services work -signposting families to specific support such as those with low income - younger parents, homelessness and domestic violence and minority support groups such as LGBTQ+, those with learning difficulties, physical difficulties and BAME.

The trust told us they were in the process of changing the website to make information on maternity services more accessible to women and partners. We were not aware of a definitive timeframe for completion of this but had been told work had started. This included information about what women and partners can expect at each stage of pregnancy and including once their child has been born. It will also include information on the different ward areas, what equipment might be used and it's intended purpose and clinical information the reader would be able to easily understand.

A consultant midwife carried out a question and answer session which women could attend with their partners. This was offered out at different times each month and questions could be asked anonymously if required. Staff we spoke with told us they thought this was a great way of helping partners to ask questions discreetly and to inform them of the pregnancy and birthing process as there had been a recognition that much information centres around the women.

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.

Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

Maternity

There was a commitment to safety, learning and improvement, which, required a firm commitment to supporting staff through induction, training, and processes of review. This created a culture of learning and improvement rather than defensiveness and blame. The trust won an Integrated Safeguarding Leads award for their commitment and dedication to their roles within the Integrated Team and the wider trust, including within the maternity services.

Although the role of consultant midwife was new in 2022, they had plans to develop the role and ensure continuous improvement and innovation was the centrepiece of their commitment to the service. The consultant midwife worked closely with other consultant midwives at a local and national level and had started to plan out services which existed in other areas, with a view of adapting it to the needs of the local population.

Outstanding practice

The trust ensured the safety of women with the support of staff to achieve their roles in an environment conducive to learning and development.

Areas for improvement

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

Action the trust SHOULD take to improve:

- The trust should ensure they are monitoring, analysing and evaluating triage times and use these findings to improve the service for women.
- The trust should ensure medicines administration is recorded clearly.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one inspection manager, a second team inspector, two inspectors and two specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.