Care Quality Commission

Hampshire Hospitals NHS Foundation Trust

Basingstoke and North Hampshire Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Basingstoke and North Hampshire Hospital

Inspected but not rated

We carried out this unannounced focused inspection of maternity services because we received information giving us concerns about the safety and quality of the service.

Information of concern had been received from several sources about the maternity services across the trust. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

Hampshire Hospitals NHS Foundation Trust provides maternity services at Basingstoke and North Hampshire Hospital, Royal Hampshire County Hospital and Andover War Memorial Hospital. This report focuses on our findings at Basingstoke and North Hampshire Hospital.

This inspection has not changed the rating of the location overall. However, our rating of maternity went down because our ratings limiters were applied due to enforcement action.

We did not change the rating of the hospital. Our rating of maternity safe and well led went down. We rated them as requires improvement because:

- We found breaches of regulations reducing the quality of care or people's experience and have taken enforcement action under regulations for safety, safeguarding and governance. Our ratings rules say that in these circumstances the rating will normally be limited to requires improvement.

How we carried out the inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities in maternity services. We carried out a focused inspection related to the concerns raised. This did not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe, effective and well-led.

We visited clinical areas including the delivery suite, the postnatal and antenatal ward and the maternity day assessment unit (MDAU).

We spoke with 20 staff, including service leads, midwives (bands 5-7), obstetric staff, consultant anaesthetists, obstetric theatre staff, maternity care support workers, student midwives and the patient safety lead.

We observed the morning multidisciplinary handover on the delivery suite and the morning handover on the postnatal and antenatal ward.

We reviewed four sets of maternity records and prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

Our findings

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

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have enough staff to care for women and keep them safe and staff did not always have time to complete training in key skills. Staff did not always identify and act on risks to women in a timely manner. The service did not manage safety incidents well and ensure changes in practice were shared widely. The service did not ensure essential equipment checks were completed and the environment did not meet national guidelines.
- Leaders did not have reliable, up to date information and understanding to ensure risks and priorities in the service were managed. Senior leaders were not always visible and approachable in the service. Some staff felt respected and valued, but senior staff did not always create a culture which supported individuals and responded to concerns.

However:

- Staff understood how to protect women from abuse and worked well with other agencies to do so.
- Multidisciplinary worked well together for the benefit of women.
- The service managed medicines well.
- The service had identified concerns with the culture of the service and had started a culture change programme.
- Staff felt there was a no blame culture across the service.
- The service had an inclusive culture which ensured family or partners could support women throughout their pregnancy journey.
- Staff adhered to personal infection control procedures and the service ensured measures to reduce transmission of COVID-19 were implemented across maternity services.
- The service had implemented the A-EQUIP model to empower and develop staff to bring improvements to the quality of care into all staff's everyday role.
- The service had achieved 100% compliance with Practical Obstetric Multi-Professional Training (PROMPT) for midwives and maternity support workers and 89% compliance for medical staff.

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement

Mandatory training

The service provided mandatory training in key skills to all, but leaders did not always ensure staff had time to complete it.

Staff were not always able to keep up to date with their mandatory training. The trust used an online platform to deliver and record training. Some staff told us that, although annual mandatory training was provided by the trust, they could not attend because they were needed to work in clinical areas of the department. The service identified 13 core

statutory modules, seven of these such as basic life support, infection control, manual handling and information governance had compliance below the trust target of 90%. The remaining six modules achieved compliance above 90%. The trust told us that one of these trainings changed on 1 July 2021 and the compliance reflects the need for staff to complete revised training.

The mandatory training provided was comprehensive and met the needs of women and staff. The mandatory training programme met the standards required to meet Health and Patient Safety standards for clinical and non-clinical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff could monitor their own progress and compliance against training targets by using the online platform. Staff told us they would receive an email to notify them when they needed to attend mandatory training.

Safeguarding

Staff understood how to protect women from abuse and worked well with other agencies to do so. However, staff were not always given time to complete safeguarding training and did not always ensure women had the opportunity to disclose abuse.

Staff did not carry out domestic violence screening at every contact with pregnant women. Three members of staff told us they would not carry out domestic violence screening with a pregnant women if their partner was present, two members of staff working with pregnant women told us that it was the role of the community midwives to screen for domestic violence. We reviewed four maternity records and only one woman had been asked domestic violence screening questions.

We reviewed the maternity safeguarding children guideline policy and found it did not meet National Institute for Health and Care Excellence guideline NG201 Antenatal Care which recommends women are given an opportunity at every antenatal appointment to discuss concerns such as domestic violence. This posed a risk that women in abusive relationships would not be given the opportunity to disclose abuse. Senior staff told us there was a function in the new electronic records system which would allow notifications to be sent directly to women asking if they felt at risk of domestic violence, but this had not been widely implemented yet.

The trust had a guideline for managing missing babies, children and young people which outlined the key principles of security and action to be taken in the event of a missing baby, child or young person. However, whilst the guideline outlined security arrangements for the children’s unit in detail, it did not specify security arrangements for the maternity service. The service did not carry out any baby abduction drills from October 2020 to November 2021. Although there had been no reported incidents, there was a risk staff may not be aware of the procedure.

Staff did not always complete safeguarding training. The trust submitted data showing that by October 2021 only 74% of eligible midwifery staff had completed safeguarding children level 3, this was below the trust target of 90% and posed a risk that staff were not up to date on current procedures to safeguard children. The trust also submitted data showing that only 29% of staff had completed safeguarding adults training by October 2021. However, the trust had changed the training in July 2021 to meet national guidelines and the low compliance reflected this. In June 2021, the compliance rate had been above the trust target at 92%.

Maternity

Midwifery staff knew how to recognise and report abuse. Staff we spoke with understood and could describe their responsibilities in relation to reporting safeguarding. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Guidance was readily available and contained contact numbers of the relevant authorities, alongside an easy to follow flow chart of actions. They maternity service described strong links with the children's safeguarding team and felt able to contact them for advice if needed.

Cleanliness, infection control and hygiene

Whilst staff adhered to personal infection control procedures, we were not assured that regular cleaning and infection control measures across the service were being carried out. Some equipment was visibly dusty.

Cleaning records were not always completed up-to-date and therefore there was no assurance that ward areas were cleaned regularly. Whilst the environment looked generally clean, we found that domestic cleaning schedules on the antenatal and postnatal ward were not always completed. We also found some equipment which had not been cleaned, for example a resuscitaire on the labour ward used to provide emergency resuscitation to newborn babies was visibly dusty.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff were bare below the elbows, decontaminated their hands after each patient contact and used personal protective equipment (PPE) such as gloves and aprons when performing clinical duties. Staff wore masks to comply with measures to reduce transmission of COVID-19 and we observed that they had changed some of their practices such as limiting the number of people in offices and patient bays to ensure social distancing was maintained.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Staff did not always carry out daily safety checks of essential equipment. We reviewed two emergency trolleys and the emergency bag in the maternity day assessment unit, none of which had all the daily checks completed. The emergency trolley on the postnatal ward had not been checked seven times in September 2021, six times in October 2021 and four times from 1 November 2021 to 16 November 2021. We found two sodium bicarbonate vials out of date on postnatal emergency trolley despite two full checks of the trolley since the medicine expired. This posed a risk patients could be given expired medicine in an emergency. The maternity day assessment unit emergency bag had not been checked 15 times in September 2021, 14 times in October 2021 and seven times from 1 November 2021 to 16 November 2021, this means on average it was only being checked approximately half the times it should have been checked. We found nine pairs of sterile gloves which had expired in June, July and August 2021. Whilst this was not an immediate patient safety issue, it did demonstrate essential equipment was not being checked regularly. We raised both these issues immediately with clinical staff who replaced the expired stock.

The emergency trolley in the antenatal ward had not been checked four times from 1 to 16 November 2021 but we did not find any expired stock on this trolley. However, one check on the defibrillator in September 2021 was recorded as 'failed'. Senior staff told us there should have been a printout of the defibrillator check but it was not present. There was no record of the fault or any action to resolve it and the next test was three days later. There was no incident report completed for this so it was not possible to track the actions. This posed a risk that faults for essential equipment were not being reported or actioned, or that staff would not know if they were actioned.

Maternity

We reviewed the daily equipment checklists and found there were 40 gaps in checking the resuscitaires across the unit between 1 and 16 November 2021. There were 11 occasions where oxygen and suction had not been checked in all eight rooms and the observation bay, three days where the blood gas machine had not been checked and five days where the anaphylaxis box had not been checked. This posed a risk that essential equipment would not be in good working order if required in an emergency.

The environment was not always well maintained to ensure the safety of women and babies. In labour ward we observed four holes in the floor and staff told us rooms we could not access also had poor flooring. This posed a health a safety risk to women and newborn babies. Following our inspection, the trust told us they would replace the flooring.

The service did not always have enough suitable equipment to help them to safely care for women and babies. We observed staff did not have enough equipment to carry out basic observations on women. In one case equipment had to be shared by two patients while midwifery staff tried to find additional equipment. Staff told us there should be enough equipment for broken equipment to be removed and fixed when needed but this was not always the case.

The design of the environment did not always ensure the security of women and babies. Whilst, there was secure access to the antenatal ward, postnatal ward and delivery suite via swipe card for staff or intercom for visitors, we were able to access the unit on the morning of our inspection without using the intercom as a member of staff allowed us to enter as they left the unit. The staff member did not ask for identification or our purpose to be on the unit. A member of staff also allowed us to enter the building where maternity services are located via a staff entrance without asking for identification. This posed a security risk for women and babies that unauthorised visitors could access the maternity unit.

The maternity theatre changing rooms were located through double doors from the postnatal ward. Although there was a 'staff only' sign, there was no security system such as swipe card or door code access and we were able to access the female changing rooms without seeing a member of staff on three separate occasions. This posed a risk that unauthorised visitors could access the changing area and theatre scrubs without staff being aware. This was included on the maternity risk register in February 2021, the actions included the current signage advising patients that the area is for staff only.

The service had suitable facilities to meet the needs of women's families. Partners were welcomed to stay with women throughout their stay in the maternity service, at antenatal appointments and in the maternity day assessment unit. The service also had a bereavement suite for families who had suffered a loss. The suite was in use on the day of our inspection and therefore we were unable to inspect this area.

Staff disposed of clinical waste safely. All clinical areas had sharps bin and clinical waste facilities. Clinical waste was separated and placed in the correct bins.

Assessing and responding to patient risk

The service had a comprehensive risk assessment system, but staff did not always identify and act on women at risk of deterioration quickly.

Staff did not always identify and treat sepsis in line with national guidance. We observed that a woman on the labour ward recorded two separate temperatures, but this did not trigger the sepsis protocol despite staff handing over that the patient had commenced antibiotics when they had not. The service had also had a recent serious incident where sepsis screening and treatment did not follow trust policy. NICE guideline (QS192) Intrapartum care: existing medical

conditions and obstetric complications (February 2020) quality statement 4 states, "pregnant women in labour with sepsis have an immediate review by a senior clinician decision maker and antibiotics are given within 1 hour if indicated. This is also reflected in the Trust policy for the management of sepsis. We raised this issue as an immediate area of concern to the trust and they developed an action plan to address these concerns.

The maternity service had reported six pressure area injury incidents since between January and July 2021. The service had recognised this as a concern and were reviewing their local policy for risk assessing skin integrity.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the Birmingham symptom-specific obstetric triage system (BSOTS) to ensure pregnant women received a standardised initial assessment and was prioritised in order of clinical need in line with the Royal Society of Obstetricians and Gynaecology guidelines. We observed staff using this system in the maternity day assessment unit.

The service aimed to triage women within 15 minutes of arrival. The service submitted an audit of triage times carried out from February to April 2021 which showed the service achieved the 15 minute triage time for 60-90% of patients. However, when we visited the unit staff were extremely busy and out of 12 patients seen that morning only one had the time of arrival and time of triage recorded on their records. There was a whiteboard in the maternity day assessment unit office with details of all women who were in the unit. When we visited there were six women listed on the whiteboard, all had times of arrival, but none had a triage time. Therefore, we could not be assured that staff consistently triaged women within 15 minutes.

Staff communicated key information during handover to keep women and babies safe. We observed handovers on the antenatal, postnatal and labour ward and although key information was shared, this was not always in a structured way. On some wards, we found staff needing to ask additional questions for clarification and the plan from the medical team was not always clear. Staff did not always identify risk factors in handover, for example a woman who had just given birth was in pain and not mobilising, there was no discussion or handover about how to manage her pain and ensure pressure areas remained intact.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff told us they used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed four MEOWS charts during the inspection and found them to be correctly completed.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. We saw contact details for these teams displayed in staff offices. One junior staff member told us they had concerns about a woman's mental health and when they escalated this, it was taken seriously, and specialist mental health support was sought for the patient.

The service had not successfully implemented the four recommendations from the Chief Midwifery Officer for England to reduce the additional risk of COVID-19 for women from black, Asian and minority ethnic (BAME) groups. Whilst senior staff told us posters had been displayed and community staff had checklists to identify women at increased risk, no members of staff we spoke to knew about additional measures to protect this group of women.

Maternity staffing

There were not always enough staff with the right qualifications, skills, training and experience to meet the needs of women and babies in the maternity service. Managers systematically reviewed staffing but were not always able to deploy staff to meet the needs of women on the unit.

Maternity

There were not enough staff to keep babies and women safe. The service used a recognised acuity tool to calculate the number of midwives required to staff the antenatal, postnatal and labour ward, this showed that nine midwives were required. However, on the morning of our inspection, there were only five registered midwives on duty at the start of the shift, due to staff illness. Further information provided after inspection reflected that by 11:15 am nine midwives were on shift to fill the rota.

There was only one midwife allocated to the antenatal ward which meant when the midwife needed to carry out procedures or treatment such as an induction of labour, there was no registered midwife for the rest of the ward. During our inspection there was an emergency call on the labour ward which the antenatal midwife attended. Therefore, a student midwife was left alone and in charge of six patients. This posed a risk of safety to women.

There was one midwife, one registered nurse and a midwifery support worker allocated to the postnatal ward at Basingstoke and North Hampshire Hospital. The rota reflected that two nursery nurses should have also been allocated to the ward. The registered nurse was new in post and had not completed all her competencies which meant one midwife was responsible for the care of 11 women and 12 babies. This posed a risk that deterioration of women and babies may not be recognised and placed additional pressure on one midwife.

Since our inspection the trust have increased the number of midwives required for each shift to 10 so two midwives can be on the antenatal and postnatal ward. However, this would only possible if staff were available.

The service used national guidance from the Royal College of Obstetricians and Gynaecologists / Royal College of Midwives (2007) to inform safe care midwife to birth ratios. Guidance stated these should be 1 midwife to 30 births. Data from the trust showed for the four months prior to the inspection ratios were worse than recommendations; July 2021 1:33, August 2021 1:35, September 2021 1:35 and October 2021 1:33.

The labour ward coordinator role was supernumerary to ensure a senior midwife had oversight of the service and to provide support and clinical advice to staff. However, staff told us that they were regularly not supernumerary due to staff shortages

The vacancy rate for registered midwives was increasing. The service reported the vacancy rate for registered midwives was 8.68% in September 2021, this had risen from 6.6% in August 2021 and was 11% at the time of our inspection. Staffing within maternity services is a nationally recognised concern. This also reflected recommendations in the National Ockenden report for additional maternity staffing investment. However, the vacancy rate for midwifery support workers had reduced from 1.28% in August 2021 to 0.91% in September 2021. Senior staff told us they had recruited staff including newly qualified midwives and international candidates to help with the staffing gap.

Women experienced delays (over four hours) to elective caesarean sections. Data from the Trust’s maternity dashboard showed the service delayed 18 caesarean sections in August 2021, 16 in September 2021 and 12 in October 2021. The staff we spoke with confirmed this and told us the service frequently delayed caesarean sections.

There were also delays (over four hours) to inductions of labour. Data from the Trust’s maternity dashboard showed the service delayed 48 inductions of labour in August 2021, and 27 in both September and October 2021. Staff told us it was common for women to have their induction of labour delayed for two days. Delay in induction by over two hours is a midwifery red flag event which is defined by the National Institute for Health and Care Excellence (NICE) Safer Midwifery Staffing for Maternity Settings as a warning sign that something may be wrong with midwifery staffing.

Maternity

Managers tried to get enough staff to staff the unit in line with the rota but did not use an acuity tool to assess changing patient acuity and staffing requirements. On the day of our inspection, the shift started with a gap of three midwives across the antenatal, postnatal and labour ward. Whilst senior staff did source additional staff by using specialist midwives clinically and asking staff to work additional hours, we did not see the use of a recognised acuity tool to ensure staff were deployed to meet the needs of women and babies. Staff confirmed to us they did not use a recognised acuity tool to assess staffing requirements on the ward on a day to day basis.

The service had high sickness rates. Data supplied by the trust in the October safer staffing report showed the sickness rate for registered midwives had increased from 10.33% in August 2021 to 10.5% in September 2021. Of this, 3.43% was reported as COVID-19 related sickness and 7.07% was reported as other sickness. This was above the trust target of 3% and significantly higher than the sickness rate for registered nurses in the trust.

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.

The service had enough medical staff to keep women and babies safe. Consultants were on site from 8am to 5pm, Monday to Friday. There was a night handover at 7pm for midwives and 8pm for consultants, which ensured a continuity of care.

The service always had a consultant on call during evenings and weekends. Consultants said they stayed on if there was high acuity on the delivery suite. Junior doctors who are speciality trainees with four and five years training could call consultants for support with any cases going to theatre. The trust advised they had online guidance for what on call consultants are expected to attend to in person. However, medical staff told us there were informal arrangements for attending out of hours. All staff confirmed these arrangements worked well and consultants were responsive to requests for support from colleagues.

Doctors completed ward rounds during the day, one in the morning, one in the afternoon and one in the evening. Staff told us that medical staff were responsive when calling them in. Staff told us they had good communications with doctors and felt confident to escalate any concerns to them.

Records

Whilst staff kept comprehensive records, they were not always easy to follow or easily accessible to all staff providing care.

Women's records were completed but staff could not always access them easily. The service had implemented a new electronic record system in May 2021 but still used some paper records. During our inspection there was a national outage of the electronic records system which meant staff were not able to access women's records. We observed a member of staff stayed 90 minutes after their shift had finished to recreate notes that appeared to have been lost, three babies could not be registered, and staff told us some babies had been given two NHS numbers. This meant there was potential for inaccurate record keeping and errors which may put women and babies at risk.

The service had two midwives to help implement and support the new digital system. They also provided training and troubleshooting advice to staff. Staff told us they did not have access to enough digital support at night, there was a helpline available, however staff reported they did not find it helpful.

Access to the electronic records system was via secure login details, personalised for each member of staff.

We reviewed four sets of records and found that although records had been completed, staff could not easily locate clinical information as some was stored in electronic records and some in paper records. The midwife assisting us with our review had to cross reference between the notes several times to provide information, this posed a risk that essential information would not be available to staff.

Medicines

The service stored medicines safely and securely. There were multiple systems for recording medicine administration which posed a risk of inaccuracies in administration.

The trust had implemented a new electronic prescribing and medicines administration (EPMA) system at the beginning of November 2021. However, staff told us that medicines were also recorded in women's paper notes and on the electronic records system. This meant staff had to check three different places before administrating medicines. A senior member of staff told us there had been an incident where an overdose of paracetamol had been administered as staff did not have time to check all three areas. This was not included on the maternity risk register.

Medicines were stored securely in line with national guidance. Medical gases were stored safely and securely in an upright position. They were stored in well ventilated areas away from heat, light sources and other flammable materials.

Incidents

The service did not manage safety incidents well. Whilst staff reported incidents, they did not consistently get feedback and lessons learned were not shared effectively with the whole team and wider service. Serious incidents were investigated but often did not identify effective immediate and long term actions to prevent them reoccurring.

The trust used an electronic incident reporting system which all staff had access to. Staff knew how to report concerns and could share examples of when they had done so but did not always receive feedback. Staff consistently told us they did not always get feedback from incidents or concerns raised, even when these were serious issues, such as no one responding to an emergency call or staffing concerns.

Incidents at ward level were reported via the electronic reporting system. Incidents were then reviewed and escalated to the clinical governance lead.

Following the incident review meeting, any incident rated as moderate harm or above was prepared as a 72-hour briefing and submitted to a 48-hour panel via Central Governance Department. The incidents were then declared as a Serious Incidents or allocated for local RCA investigation.

After completion of the investigation the findings of the reports were shared with the staff, the woman, the Maternity Safety Champions, presented at Maternity Clinical Governance Committee and summarised for the Quality and Performance Report.

Where feedback was received, this was not always helpful or meaningful. We reviewed a maternity red flag incident from September 2021 where one to one care could not be provided on the delivery suite. The feedback from this incident was that maternity staffing remained under review, acknowledged it was stressful for staff, thanked them for their continued hard work and asked them to keep reporting staffing concerns. The feedback did not highlight any immediate actions senior staff were taking to address this concern to ensure it did not reoccur. This could potentially discourage staff from reporting incidents.

Maternity

Managers did not share lessons learned effectively. Staff we spoke with during our inspection could not tell us any learning from recent incidents. Senior staff told us that they communicated learning through several channels such as emails, message groups, posters and videos but these were not effective. During our inspection, staff raised a never event which occurred in August 2020 on the Winchester site, where a procedure was carried out without consent. Midwifery and medical staff across the service told us the only learning shared was the termination of the staff member's employment with the trust.

The service held a weekly meeting to discuss incidents. Senior staff told us that all grades of staff were invited but only senior staff usually attended as junior medical and midwifery staff were working clinically on the wards.

The service reported 13 serious incidents across from October 2020 to September 2021, this included one maternal death. Eight of these incidents had been reported to the Maternity Healthcare Safety Investigation Branch. We reviewed the initial incident reports for some of these incidents and found they did not identify any immediate actions to reduce the risk of these incidents reoccurring.

Managers debriefed and supported staff after any serious incident. The trust had a 'hot debrief' process whereby staff were supported following any traumatic incidents within their specific shift. Staff were also supported by trauma trained professional Midwifery Advocates via virtual meeting sessions. Educational feedback was given to any medical staff who required it.

Is the service effective?

Insufficient evidence to rate

Our rating of effective stayed the same.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice, however we noted the absence of some guidelines.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

The service had 67 guidelines and policies and 10 standard operating policies (SOP's), 87% of these were in date, the service recognised some policies and guidelines required review and had a plan to complete this. Clear indications at the start of the document referenced recent changes. Policies were dated when reviewed and there was an indication of the next review date.

There were no specific guidelines for reduced fetal movements, out of hours attendance for consultants and the Birmingham Obstetric Triage System (BSOTS). Staff told us that there were informal arrangements for out of hours consultant cover, and these arrangements worked well. We saw BSOTS being used but the absence of a formal guideline meant the service could not be assured that staff were applying the principles correctly.

Staff completed mental health training as part of their mandatory training.

Maternity

The service was functioning in line with current government guidance in relation to COVID- 19. We saw signage relating to the numbers of people allowed in each area and we saw signage to advise on COVID-19 procedures.

Patient outcomes

Staff monitored the effectiveness of care and treatment but information was not always up to date and therefore could not always be used to make improvements and achieve good outcomes for women.

The maternity service had defined performance measures and key performance indicators (KPIs), which were recorded and monitored using the maternity dashboard. The maternity dashboard parameters were presented in a structured format. The parameters had been set in agreement with local and national thresholds which allowed the service to benchmark themselves against other NHS acute trusts.

It was unclear how the service used monitoring results to improve safety. On day of our inspection the maternity dashboard was not up to date and some elements of the data were not immediately available to us. Which meant they were also not available to the service to inform them of their own position.

The service participated in relevant national clinical audits. 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.

The rates of third and fourth degree tears was above (worse than) the national average. In June 2021 the trust reported 43 third and fourth degree tears per 1,000 births compared to 25 per 1,000 births nationally. In August 2021, data submitted by the trust showed incidents had risen to a rate of approximately 4%. This was significantly higher than at the trust's other maternity site in Winchester.

In June 2021, the trust was above the national average for the number of babies born with an APGAR score of between 0 and six. An APGAR score is a measure for professionals to assess the health of newborns at one and five minutes after birth. The score is determined through the evaluation of five criteria; appearance, pulse, grimace, activity and respiration. Scores of seven and above are classed as normal, scores of four to six are fairly low and a score of three or below is classed as critically low.

The service met the national target of 5% for avoiding term admissions into the neonatal unit (ATTAIN). The admission rate for the hospital was 4.5%.

Competent staff

The service provided support to make sure staff were competent for their roles, but staff did not always have time to access it.

There were concerns that staff were sometimes allocated tasks beyond their competency level.

Some staff raised concerns that student midwives or registered nurses without midwifery competencies were given inappropriate tasks for their level of training or experience. The service had recently held a band 5 listening event where staff had highlighted they sometimes felt “out of their depth” with high risk cases and unable to say no. During our inspection we observed a member of staff in the wrong uniform. This posed a risk that other staff or patients may expect the member of staff to be able to carry out tasks above their competency level based on their uniform. We raised this to senior staff immediately and the member of staff changed their uniform.

Maternity

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Data submitted by the trust showed 84% of medical staff and 65% of midwives and other clinical staff had received an appraisal. Senior staff told us completion of appraisals was challenging and they aware staff were not receiving appraisals or not receiving the full time for their appraisal. The trust told us the senior management team were monitoring the appraisal process. However, this posed a risk that staff were not receiving support and constructive review of their work to aid performance and development.

Managers gave all new staff a full induction tailored to their role before they started work. Staff worked through a competency booklet and worked supernumerary for a period of time until they felt confident and were assessed as competent in their roles. The midwife care assistants had undertaken training to ensure they were competent to undertake observations and maintain the MEOWs charts. New staff we spoke with staff confirmed this was the case.

Clinical educators supported the learning and development needs of staff but their ability to deliver the role was constrained by staffing issues. Practice development midwives were passionate and delivery high quality training and support for staff. A clinical educator met with all band 5 and 6 staff once to year to ensure they had completed mandatory training and any targets set at their appraisals. The team had recently implemented a rotational preceptorship programme which included a week supernumerary on each ward to allow newly qualified midwives to build skills in different clinical areas. Student midwives also received study days such as fetal monitoring whilst completing placements on the wards. The practice development team were experiencing staff shortages and were also frequently asked to cover clinical staffing gaps which limited their ability to focus on clinical education. In August 2021, no skills workshops were held as the practice development team worked at least 75% of their hours clinically.

The trust had implemented the advocating for education and quality improvement (A-EQUIP) model. A-EQUIP is a continuous improvement process designed to empower and develop staff so that action to improve quality of care becomes a part of everyone's job.

There was a professional midwifery advocate (PMA) team and staff had specific support following traumatic events. The PMA role is a recognised means of supporting midwives, through restorative clinical supervision, now formal supervision had been discontinued. There were five PMA's in post. All maternity staff, including midwives, had access to well-being services provided by the trust.

The service had introduced a fetal monitoring study day which included cardiotocography (CTG) training and drills. Trust data showed that fetal monitoring training for doctors and midwives showed had a compliance of 43% for doctors and 26% for midwives. There was also a weekly multidisciplinary CTG meeting where case studies were discussed and staff were expected to attend three sessions a year to maintain their competency. Some staff told us it was not possible to attend these meetings because of staff shortages.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Most staff we spoke with told us that there were good working relationships between medical and midwifery staff. Staff described there was good teamwork and midwifery staff felt consultants had the same common goal to provide a high quality of care to women.

We also observed good team working across the different maternity wards and positive interactions between midwives, registered nurses and midwifery support workers.

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Obstetricians were on the hospital site until 8.30 pm on weekdays. After that time there was an on-call rota and clinical advice could be sought over the telephone or the obstetrician would come to the hospital in person.

We could not be assured ward rounds were always multidisciplinary on the weekend. Discussions with staff and audit information were inconsistent on this matter.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They were not always able to understand and manage the priorities and issues the service faced. Senior leaders were not visible and approachable in the service for patients and staff.

Maternity was part of the Family and Clinical Support Services Division across Hampshire Hospitals NHS Trust. The head of midwifery and clinical director was cross-site and covered both the Winchester site and the Basingstoke site. To support the associate director of midwifery, there was a deputy head of midwifery based at each site.

At the Basingstoke site there was a community matron and a governance and safety lead who reported to the deputy head of midwifery. There was a vacancy for an inpatient matron which staff told us put additional pressure on the labour ward coordinator.

Staff did not always have confidence in the senior leadership team. During our inspection there was an outage of the electronic records system. The service had a contingency plan, however, staff told us they received conflicting messages from managers and did not have confidence the electronic system would update information.

Local senior leaders in the unit tried to manage the staffing levels and frequently worked clinically, undertaking many front-line roles. This showed support for staff but it meant they were unable to undertake their leadership roles and safety oversight of the unit.

Staff told us some senior leaders were not always visible in the service. The leadership team did not successfully engage with all staff. Whilst the service had several communication strategies such as emails, social media, newsletters and message groups, staff repeatedly told us they did not always receive key messages. We observed staff did not always know key information for example, when the electronic records system failed, senior staff told us they sent out emails and screen sprinkles to give guidance to staff but these were not read by staff. Senior staff told us they expected all staff to read emails but they did not assess whether this was effective or met the needs of everyone, particularly junior staff.

Culture

Staff were focused on the needs of patients receiving care. They generally felt respected and valued, but senior staff did not always create a culture which supported individuals and although staff raised concerns these were not always acted upon. However, the service had identified some culture concerns and had taken steps to address these.

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Staff we met during our inspection were welcoming, friendly and helpful. They felt pride in the support they provided each other and having worked together to provide the best service they could to patients in their care.

Staff felt able to speak up but their concerns were not always acted upon. Staff across the service and at varying levels of seniority told us that they had raised concerns about issues such as staffing and equipment but had not received a response.

The most common reason for sickness in the maternity service was anxiety, stress, depression and other psychiatric illness. This accounted for 22.7% of the maternity service sickness.

The service had recently held a virtual pizza evening with junior midwives to obtain their views on working in the service. Staff highlighted concerns such as difficulty transitioning to become one of the team and conflicts between staff grades, for instance, more senior staff being disrespectful about junior staff on shift which lowered confidence and morale and junior staff being sent to another ward when more senior staff were available but refused to go. Staff also raised they didn’t always feel empowered to refuse tasks they felt out of their competency level such as looking after multiple women in labour, caring for high dependency patients and being allocated students. The service outlined action that band five staff would not be allocated students in the future.

Culture concerns had been identified as a key concern across the maternity service by staff and the leadership team. The service had a maternity culture change project in pilot stage. This project included work development opportunities, culture workshops and introducing a new communications strategy.

The service had identified a high turnover rate for midwifery staff and had carried out retrospective exit interviews with all staff who had left within the last 12 months. This highlighted behaviour and communication concerns with a key group of senior staff. The service has implemented targeted training and feedback opportunities for this group of staff. Whilst this was only a recent development, staff reported they could see improvements in the behaviour of staff.

The service ran a ‘civility saves lives’ campaign across the services highlighting the impact positive interactions between staff have on reducing errors and stress. Staff told us respect and working relationships between staff, particularly medical and midwifery colleagues had improved.

Medical and midwifery staff across the service told us there was a no blame culture and they could raise concerns with senior staff. The service held a wellbeing every two months for medical staff and staff told us they received wellbeing support after a serious incident had occurred.

Management of governance, risk, issues and performance

Leaders and teams used systems to manage performance, but this was not always effective. When they identified and escalated relevant risks and issues they were not always actively managed to reduce their impact. They had plans to cope with unexpected events which were not always adhered to.

Leaders felt there was a good risk structure in place and good management support of risk. They described the process of reviewing incidents within the trust used a framework and standard operating procedure to grade levels of harm which then informed judgements about appropriate care in line with guidelines. This also informed the escalation of serious cases. The risk lead sat on the open incidents review 48 hours panel so had oversight of current issues and risks. Within the panel were midwives, obstetricians and, when required, specialists such as radiographers.

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When incidents occurred, a case review was done within 48 hours by a multidisciplinary panel, followed by a full root cause analysis within national incident investigation timescales'. Feedback was shared following the analysis, identifying outcomes and reviews and includes addressing duty of candour, feedback to the trust, patients, families and staff including any educational needs. The midwifery risk management team dealt with external reporting to the Health Safety Investigation Board and educational practice midwives provided feedback to specific midwife related issues.

Leaders identified risks but did not always manage them well. There was a maternity risk register which included a description of each risk, control measures including any gaps in control measures and a summary of actions taken. The risk rating, status and any updates were also included. However, we were not assured that all risks were rated correctly. Maternity staffing was added to the risk register initially in November 2012 and most recently updated in October 2021 rated as amber with a risk score of 12. However, during our inspection we saw staffing had a significant impact on the safety and quality of services provided to women and babies. For example, delays in elective caesarean sections and inductions of labour, gaps in checking essential equipment and potentially unsafe levels of staffing on wards. These risks had not been identified and highlighted on the risk register. The control measures documented staffing levels required and a business case for June 2014, meaning it had not been updated to identify current control measures.

The service collected data but it was not always managed so that up-to-date, accurate information was available to understand performance and make decisions and improvements. Data and information was not always used and analysed effectively to assess and improve performance. The maternity dashboard was not always kept up to date or shared with staff. This meant leaders and staff did not always have timely and reliable date to inform them what was happening within their service.

On three occasions in the process of our inspection, the service provided information which was either incorrect or not up to date.

The trust submitted a midwifery red flag audit which showed only one midwifery red flag had been reported between August and October 2021. However, the trust also submitted their maternity dashboard which showed the service delayed (by over four hours) 48 inductions of labour in August 2021, and 27 in both September and October 2021. A midwifery red flag should be reported when there is a delay of more than two hours between admission for induction and beginning the process. We saw staffing had an impact in several areas including checking of equipment, safety of women and babies and delays in care. The incorrect reporting of red flags meant the extent of level of concern for midwifery staffing may not have been visible to the trust.

Information Management

The service did not always collect reliable data analysis. However, information systems were integrated and secure.

The service had electronic systems for collecting and analysing data. However, data and information was not always kept up to date and used effectively.

Data stored by the trust remained confidential and was stored securely. All areas had password protected computer terminals for staff to access information. All computer terminals were password protected when not in use. The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly, and patient names were not visible from the ward areas which ensured privacy.

The trust operated an electronic and paper-based records systems for clinical records.

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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 patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, the service did not always effectively engage with staff.

Outside of the pandemic leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. However, this level of engagement was affected by the pandemic and the current staffing shortage.

The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP).

The trust used a range of communication tools to aid learning and development. This included newsletters, emails, hot topics. However, staff did not always have time to read or engage in these methods of communication because they were prioritising clinical care. This meant during busy times the usual communications tools used to share learning and key messages were having little impact.

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:

- The trust must ensure all staff identify and treat sepsis in a timely way according to trust policy and national guidelines. (Regulation 12(1)).
- The trust must ensure the environment meets national guidance and is able to be cleaned effectively to maintain infection control standards. (Regulation 12 (1)).
- The service must ensure regular checks on emergency and essential equipment are carried out. (Regulation 12 (1)).
- The trust must ensure the security arrangements for the maternity unit and staff only areas of the maternity unit keep women and babies safe. (Regulation 12 (1)).
- The trust must ensure national guidelines are followed when screening women for a risk of domestic violence and trust policy reflects this. (Regulation 13(1) & 13(2)).
- The trust must ensure data is managed so it is up to date, reliable and can aid decisions about risk and performance in the service. Midwifery red flag reporting must accurately reflects risk. Regulation 17(1).
- The trust must ensure that they gather and share learning from incidents to evaluate and improve the service (Regulation 17).

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- The trust must ensure that staffing levels are managed across the midwifery service to ensure the safety of women and babies. (Regulation 18(1).

Action the trust SHOULD take to improve:

- The trust should ensure there are clinical guidelines for reduced fetal movements, out of hours attendance and the triage system. (Regulation 12).
- The trust should ensure staff do not undertake roles outside of their competency level (Regulation 12).
- The trust should ensure all staff receive an appraisal (Regulation 12).
- The service should ensure the four recommendations to reduce the risk of COVID-19 for women from a BAME background are implemented. (Regulation 12).
- The trust should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18).

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and two specialist advisors. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance