Portsmouth Hospitals University NHS Trust

St Mary's Hospital

Inspection report

Milton Road
Portsmouth
PO3 6AD
Tel: 02392286000
www.porthosp.nhs.uk

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Ratings

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

Our findings

Overall summary of services at St Mary's Hospital

Good

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at St Mary's Hospital

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

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

Portsmouth Maternity Centre is located on the second floor of St Mary's Hospital provides maternity services to the population of Portsmouth, Southsea, Havant and the surrounding areas.

Maternity services at St Mary's Hospital include antenatal, intrapartum (care during labour and delivery) and postnatal maternity care. The service has six clinic rooms and two delivery rooms with ensuite facilities and one with a birthing pool.

Portsmouth Maternity Centre is open 8am to 8pm Monday to Friday and 8am to 5pm at the weekend for antenatal and postnatal clinics. Out of these hours, care is provided to women and birthing people on an on-call basis.

Intrapartum care activity levels at Portsmouth Maternity Centre were low. Between October 2022 and October 2023, 10 babies were born at St Mary's Hospital. There were no births at the Portsmouth Maternity Centre in November 2022 and February, April, May, June, August 2023.

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.

We had not previously inspected maternity services St Mary's Hospital.

We also inspected 2 other maternity services run by Portsmouth University Hospitals NHS Trust.

Our reports are here:

- Queen Alexandra Hospital - https://www.cqc.org.uk/location/RHU03
- Gosport War Memorial Hospital - https://www.cqc.org.uk/location/RHU10

How we carried out the inspection

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

Our findings

We visited the birthing and clinic rooms.

We spoke with 3 midwives, including the birth centre lead midwife.

We reviewed 3 patient care records.

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

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

Maternity

Good

We had not previously rated this service. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.
- The service-controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had enough midwifery staff planned.
- Staff assessed risks to woman and birthing people, acted on them and kept good care records.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff were clear about their roles and accountabilities.
- The service engaged well with woman and birthing people and the community to plan and manage services.

However:

- There was limited evidence of learning from incidents.
- Leaders could improve the effectiveness of oversight of transfers from the free-standing midwifery units to the main hospital site.

Is the service safe?

Good

We had not previously rated this service. We rated it as good.

Mandatory training

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

Midwifery staff received and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed professional obstetric multidisciplinary training (PrOMPT) training once a year. Data showed as of October 2023, 89% of midwives and 85% of maternity support workers across the trust had completed yearly PrOMPT training.

Staff completed regular skills and drills training. For example, staff had recently completed pool evacuation training and training with the local ambulance service on transfer to the main hospital site. Across the trust, as of October 2023, 93% of midwives and 81% of maternity support workers had completed yearly training in pool cleaning, waterbirth, pool evacuation and hoist training.

Maternity

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with, had completed online safeguarding training in the past year. As of October 2023, trust data showed 90% of midwifery staff and 84% of midwifery support workers had completed safeguarding children level 3 training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding midwives and had community midwives had regular safeguarding supervision.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Data showed hand hygiene audits were not completed between February 2023 and October 2023 at St Mary's Hospital.

The birth centre manager was aware of processes for managing and controlling the risk of legionella including regular flushing of taps on the birth centre. We saw that midwifery support workers completed checklists to confirm taps were flushed 3 times a week. The trust provided data showing the water had been tested at St Mary's Hospital in November 2022 and legionella was not detected in the water supply.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure. There was a monitored buzzer entry system to the birth centre.

Staff carried out daily safety checks of specialist equipment. Records of the last three months neonatal resuscitaire checklists showed resuscitaires were checked at every shift on labour ward.

Portsmouth maternity centre had access to an adult automated defibrillator located at the entrance to St Mary's Hospital. We reviewed the trust cardiopulmonary resuscitation policy which stated the in the event of an emergency staff should provide basic life support, use automated external defibrillation (AED) and call for an ambulance.

The service had suitable facilities to meet the needs of women and birthing people's families. For example, on the alongside midwifery-led unit women and birthing people had access to birthing pools, birth balls and stools to support movement in labour.

Maternity

The service had enough suitable equipment to help them to safely care for women, birthing people and their babies.

Staff disposed of clinical waste safely and 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. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle.

The service included review of the 'fresh ears' process for peer review of intermittent auscultation (where the midwife listens in to the fetal heartbeat at regular intervals). The October 2023 audit of compliance with 'fresh ears' reviews was of 10 cases randomly selected from records the 96 records across maternity services at the trust included in the audit period 1 July 2023 to 31 July 2023. The audit showed in 87.5% of cases 'fresh ears' reviews were completed at least every four hours in line with national guidance. The service planned to re-audit in 6 months.

Staff risk assessed women and birthing people continually antenatally and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

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

The service had processes to transfer to the main hospital site if needed. If an obstetric review was needed for someone birthing at Portsmouth Maternity Centre, midwives made decisions to transfer with support from the labour ward lead midwife and the operational bleep holder at Queen Alexandra Hospital.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people 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.

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

The Athena and Hera continuity of carer teams of midwives were based at Portsmouth Maternity Centre at St Mary's Hospital.

The birth centre lead could adjust staffing levels daily according to the needs of women and birthing people. Births at the centre were staffed by the continuity of carer team midwives and the community midwife on-call.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and birthing people accessing the service. The matron of the day completed the staffing acuity tool every 4 hours. The

service used a traffic light red, amber, green system to determine the capacity of the unit. Green status meant the unit was functioning at normal capacity, amber status meant there were insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and red status would lead to a decision to close the unit. The unit leader at the Queen Alexandra Hospital site updated the traffic light status 4 times during a 24-hour period.

Midwifery staffing levels across the trust were improving. As of the 1 October 2023 the service had 11.1 whole time equivalent (WTE) vacancies for registered midwives band 5 to 8 against a funded establishment of 235 WTE registered midwives.

Staff had access to the midwifery practice development team who were based at the main hospital site. The trust had recruited a community practice development midwife who was due to start their role in November 2023.

Records

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

Notes were comprehensive, and all staff could access them easily. The trust used an electronic records system.

We reviewed 3 records on inspection and found records were clear and completed.

Managers did not regularly audit maternity records. Managers used the incident management process to review recordkeeping following incidents. At the August 2023 birth centre leads meeting the community matron discussed introducing an audit of 5 sets of notes to be discussed with staff through the appraisal process to improve documentation.

Records were stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff had access to medicines used to respond to emergencies safely. For example, staff had access to a post-partum haemorrhage emergency response trolley and a transfer grab bag.

Incidents

There was limited evidence of learning from incidents.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

No serious incidents had occurred at Portsmouth Maternity Centre at St Mary's Hospital in the past year.

Maternity

Is the service well-led?

Good

We had not rated this service before. We rated well-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Maternity services at St Mary's Hospital were managed as part of the women and children's care group in Networked Services division at Portsmouth Hospitals University trust.

The birth centre at St Mary's Hospital was managed by a band 7 lead midwife who was supported by the community matron for the trust. The community matron reported to the Director of Midwifery and Maternity for the trust.

Vision and Strategy

There was no specific vision or strategy for Portsmouth Maternity Centre at St Mary's Hospital.

Maternity services had a clear vision and strategy. The 2020-2025 strategy was focused on three priorities: provide high quality safe care, improve the health and wellbeing of mothers and babies and delivering individualised care. The strategy was aligned with national priorities including Better Births and the NHS long term plan.

Maternity services also had a wellbeing strategy that was led by the wellbeing and retention matron.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care.

Staff we spoke with were consistently positive about working at the trust.

The service had received no complaints in relation to Portsmouth Maternity Centre in the past year.

Leaders had a strong focus on staff wellbeing and ensuring staff took time for breaks.

Governance

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

Midwifery managers with responsibility for birth centres met regularly to review safety and performance. We reviewed the last three birth centre clinical leads meetings and found workforce issues and improvements to service delivery were discussed. An action tracker was used to track actions that came out of these meetings.

Managers did not formally audit transfers out of the freestanding midwifery led birth centres to the main hospital site. We requested transfer audits for the past year and the service provided details of the 2 transfers that had occurred in the past year out of 10 births. This is a transfer rate of 20%. Both transfers occurred postnatally. The audit did not include a

review of whether the criteria for use of the birthing centre were met at the time of labour. The Emergency Transfer Guideline – Maternal and Neonatal from Community, ratified in February 2023 stated compliance with the guideline would be monitored by a yearly audit of 30 records where a transfer from the community to the main hospital site occurred.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a sample of clinical guidelines that staff had access to through the intranet and found these were up to date.

The standard operating procedure (SOP) for the freestanding midwifery led units had not been signed off at the time of inspection. Following the inspection site visit the first version of the 'Freestanding maternity Unit and Homebirth – standard operating procedures' was ratified and issued on the 26 October 2023. The SOP included the inclusion and exclusion criteria for use of the birth centre and processes for transfer.

Management of risk, issues and performance

Managers had not identified and recorded any specific risks relating to St Mary's Hospital.

Managers monitored risk across maternity services on the maternity services risk register. Top risks across maternity services were safe midwifery staffing, unknown risk of unscavenged nitrous oxide to staff and continuing to embed the maternity electronic records system. These risks were mitigated by ongoing midwifery recruitment, a working party completing a review of nitrous oxide exposure in the maternity units and regular oversight of the transfer of clinical pathways to the electronic records system.

The maternity dashboard did not include any clinical outcomes data in relation to Portsmouth Maternity Centre at St Mary's Hospital.

Information Management

The service collected reliable data and analysed it.

The service used an electronic records system.

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

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 Athena and Hera continuity of carer teams based at Portsmouth Maternity Centre held regular coffee mornings with expectant mothers and new mothers who had recently used the service to gather feedback and encourage peer support.

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity and neonatal voices partnership (MNVP). The MNVP meetings were held online and in person.

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

The service had links with the local MNVP, and they were involved in the governance of the service by attending the monthly maternity and neonatal committee meetings.

The MNVP was working with the trust on co-production and met with representatives from the trust and service users every 6 weeks to progress this work.

Following a review by the MNVP it was found that many women did not realise that Portsmouth Maternity Centre was an option for birth. At the community huddle on 11 September staff were reminded to ensure that all low-risk women were signposted to all options for place of birth as appropriate.

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

Learning, continuous improvement and innovation

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

The maternity service had an active reproductive health and childbirth research team. The service was part of a national research trials including but not limited to the multiple pregnancy registry, the national Rainbow Clinic study which aims to understand the care needed in pregnancy following a stillbirth, the Giant Panda study which aims to find out which is the best medication (labetalol or nifedipine) to treat high blood pressure in pregnant women.

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

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 SHOULD take to improve:

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- the service should audit transfers from the free-standing midwifery units to the main hospital site.
- consider reviewing processes to audit the quality of documentation.
- consider reviewing the maternity dashboard to include clinical outcomes relevant to the freestanding midwifery led unit.
- consider reviewing risk management processes for the freestanding midwifery led units.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a midwifery specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.