Hampshire Hospitals NHS Foundation Trust

Royal Hampshire County 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 Royal Hampshire County Hospital

Inspected but not rated

We carried out an 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 the Royal Hampshire County Hospital.

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.

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, morning handover on the postnatal and antenatal ward and the morning safety huddle on the delivery suite.

We reviewed five 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.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives. Before our inspection, we reviewed performance information about this service.

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. Some staff felt respected and valued, but senior staff did not always create a culture which supported individuals and responded to concerns.
- Despite local the local leadership team in Winchester being visible and approachable, staff told us the senior leadership for the service were not always visible or approachable.

However:

- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.
- Doctors, midwives and other healthcare professionals worked together as a team to benefit women.
- The service had identified concerns with the culture of the service and had started a culture change programme.
- Staff adhered to personal infection control procedures and the service implemented measures to reduce transmission of COVID-19 across maternity services.
- 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).

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 staff and but not all staff completed it.

Staff did not always receive or 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.

Maternity

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 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%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. 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.

We spoke with a staff member who advised they had done online safeguarding training. This was their first day in the department and said they felt they had had enough training and were well supported by colleagues. They said they had had basic life support training as well as other e-learning.

During the inspection we observed staff discussing safeguarding risks at handovers and clearly identifying adults and children who may be at risk of harm. However, we did see one record where the patient had not been asked a DV (Domestic Violence) question at their ante natal appointment, so we cannot be assured that all women are having risks identified or being kept safe

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they had good communications with social care teams and ward staff in relation to safeguarding. Staff knew who their safeguarding leads were and were able to name them. Staff said babies at risk have a “child in need” plan and have a discharge planning meeting before leaving hospital.

Staff could not tell us when the last abduction drill had been carried out. Although there had been no reported incidents, there was a risk staff may not be aware of the procedure. However, we saw baby name band signs on the postnatal ward for reminding staff that babies should have two name bands on at all times.

Data provided by the trust after the inspection showed there had been no training on baby abduction since October 2020. The trust policy covered paediatric and neonatal wards but had no specific mention of labour and maternity wards. The trust policy was due for review in August 2022. We could not be assured staff would know what to do in the event of a baby abduction.

Maternity

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept most of their equipment and the premises visibly clean, but some equipment was visibly dusty and there were gaps in one cleaning checklist.

Ward areas throughout the service were clean and had suitable furnishings which were clean and well-maintained. Ward chairs in the postnatal ward appeared new, made of a vinyl material, appeared well maintained and were clean. Ward cleaning checklists were visible on the postnatal ward entrance windows and were completed on the day of the inspection.

Items of medical equipment were clean, with in date "I am clean" stickers. Most of the equipment was clean and had in date "I am clean" stickers on them. However, we saw a baby resuscitaire machine, that was visibly dusty but had an "I am clean" sticker dated 26 September 2021 on it. We highlighted this during the inspection and a member of staff cleaned the resuscitaire later that day.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff performed good hand hygiene practice before and after seeing patients, they wore masks and were bare below the elbows. However, we did see a dispensing unit for gloves and aprons on the postnatal ward was empty of aprons.

Water cooler dispensing bottles were used on the postnatal and labour ward, but their cleaning schedules showed two dispensers had not been cleaned for nine days out of 16. This is an area of concern as bacteria such as pseudomonas and legionella could grow in the water bottle and dispensing nozzle. Risk assessment documents for these identified only manual handling risks and not any possible infection risks associated, therefore we could not be assured women are safe from infections.

Cleaning records were generally up-to-date and demonstrated that all areas were cleaned regularly. A ward task checklist was seen that showed staff were carrying out compulsory tasks. However, there were gaps in those tasks, specifically the cleaning of the resuscitaire.

Staff rooms and offices on the postnatal ward had a 'Rule of 3' COVID-19 guidance to enable social distancing. Staff adhered to the guidance when using staff rooms and offices.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not ensure women and babies safe. Staff managed clinical waste well.

Staff did not always complete daily safety checks of specialist equipment. For the month of November, there were 10 gaps in the daily task schedule for checking the postnatal ward resuscitaire and two gaps in checking the neonatal emergency trolley. Staff should check resuscitaires daily to ensure they are working correctly. The ward checklist allowed for twice daily checks for the resuscitaire to be recorded. A resuscitaire combines warming therapy along with the components you need for clinical emergency and resuscitation. All resuscitaires had gaps in the recording of important daily checks.

We checked the resuscitaire, and associated emergency trolley, on the postnatal ward. The trolley was secured with a tamper evident seal. However, the checklist attached to the trolley did not document the seal number so we could not be assured that specific trolley had been checked. The trolley was located on the postnatal ward and was the responsibility of the neonatal unit to maintain. The trolley did not have a corresponding trolley number on the checklist.

There was no signature or initials on the checklist to show who had checked supplies or when. Some items had expiry dates documented as overdue, but it was unclear if those items had been removed from the trolley and replaced. The checklist had each corresponding drawer and its contents listed, but the trolley itself had a missing label to one of its drawers and this could cause confusion in an emergency.

This presented a risk that equipment might not be working or available in the event of an emergency and mothers and babies could be harmed.

Staff reported they felt confident if they needed to use the trolley.

Staff reported they had enough equipment. The trust undertook electrical safety testing on electrical items of equipment.

A resuscitaire on the labour ward had visibly very worn covers on its base where medical accessories were stored and did not have an “I am clean” sticker visible anywhere on it. This piece of equipment was seen in use during our inspection for treating a baby.

The service had suitable facilities to meet the needs of women's families. The post and antenatal wards were in close proximity and was on the same floor as the labour ward, which ensured easy access for mothers and babies. The design of the environment followed national guidance. The birthing unit had additional features to support a home from home approach.

The design of the environment in most clinical areas followed national guidance. Mothers and babies were kept secure on the maternity unit. There was secure access to the central labour ward, ante-natal and post-natal wards. Maternity unit staff could access the unit with a swipe card, and patients and visitors were required to ring a buzzer and advise who they were visiting to be granted access. We observed staff preventing people from ‘tailgating’ onto the unit.

Staff disposed of clinical waste safely. We saw one sharps bin clearly labelled, not over filled and stored appropriately behind locked doors. We saw bins labelled and separated according to the type of waste within, and that appropriate waste was in the correct bins.

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 at risk of deterioration. However, the emergency call bell was not working in the Day Assessment Unit posing a risk to women in an emergency.

Staff on the antenatal ward completed risk assessments for each woman on admission or arrival to the department using a recognised tool.

Staff completed booking risk assessments for each woman at their initial booking appointment, which included social, medical and obstetric assessments. Staff updated the trust electronic patient record system with women’s information including social background, ethnicity, co-morbidities and body mass index.

Maternity

The service used the Birmingham Symptom Specific Obstetric Triage System (BSOTS) in the Day Assessment Unit (DAU). The system involved completion of a standard clinical triage assessment by a midwife within 15 minutes of a woman's attendance to define clinical urgency, guide timing of subsequent assessment and immediate care. A RAG (Red, Amber, Green) rating system was used to identify individual risks for women. The service recorded, monitored and audited the 15 minute triage time. DAU staff reviewed the audit information to inform their practice.

The emergency call bell system in the DAU was not working at the time of our inspection. Staff told us they had raised this as an incident but had not been addressed. The DAU was open until 8pm and staffed with a single midwife for the late shift (after 6pm). The DAU was located within outpatients on the ground floor of the maternity building away from the wards. However, when the outpatient clinics were closed and staff had gone home, the DAU was isolated. Staff told us should a woman become unwell in a clinic room they had to leave them unattended so that they can use the phone to dial for assistance. There was a risk women's condition could deteriorate while the midwife was out of the room. Staff also told us that emergency staff are not familiar or aware of the location of the DAU. This could cause further delay in responding to an emergency.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used the 'Modified Early Obstetric Warning Score' (MEOWS).

Staff knew about and dealt with any specific risk issues. Each woman had a patient care record which contained a variety of risk assessments. We reviewed five sets of patient care records and found all risk assessments fully completed.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. We observed a midwife to midwife shift handover which followed SBAR format (Situation, Background, Assessment and Recommendation). Midwives sought clarity on any queries and documented them in their own handover notes. Staff shared key information to keep women safe when handing over their care to others. Safeguarding issues were highlighted which could be clinically relevant. The handover also included a discussion about high-risk women. The handover included all necessary key information to keep women and babies safe. However, the handover was interrupted twice which could mean important care information could be missed and women may not be kept safe.

Midwifery staffing

The service did not always have 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, but this did not always mean they could meet the needs of women on the unit.

The service did not have enough nursing and midwifery staff to keep women and babies safe. Staff we spoke to spoke of low staffing levels and exhaustion. Several staff members mentioned the unit sometimes felt unsafe due to staffing numbers and the acuity of women on the unit. Midwives had been going above and beyond to work in extremely challenging circumstances.

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.

Maternity

Staff told us that low numbers of trained staff delayed women being discharged home. In particular new mothers were waiting to have a midwife assessment before being discharged. Staff of all grades told us it was unusual to get a break while on duty and often went home feeling dehydrated and exhausted.

The labour ward coordinator could adjust staffing levels daily according to the needs of women. Managers moved staff according to the number of women in clinical areas however staff told us this was at short notice and they could be expected to work in areas unfamiliar to them.

The number of midwives and healthcare assistants did not always match the planned numbers. Community midwives were often used to increase staffing numbers. Data from the trust for the period July to October 2021 showed there had been 84 suspensions of community births. These suspensions affected 50 women, who then needed to attend one of the hospital sites to give birth.

The service had a vacancy rate of 11% across the trust. Staffing within maternity services is a nationally recognised concern. This also reflected recommendations in the National Ockenden report for additional maternity staffing investment. The trust reported that low levels of staffing were due to long and short term sickness, COVID-19 related absence, high levels of maternity leave and continuity of carer. The unit had started to address the staffing problems and had made recruitment offers for newly qualified midwives equivalent to 9.37 whole-time equivalents.

The service had a high sickness rate of 10.21%, across the trust in August 2021. In addition, COVID-19 has affected staff absence, with the trust reporting 12% of midwifery staff absent during August 2021 due to COVID-19 related issues.

The unit had also paused the government initiative of 'continuity of carer'. The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period. This had been unachievable with the current staffing issues.

There were also delays (over four hours) to inductions of labour. Data from the trust's maternity dashboard showed the service delayed 72 inductions of labour at The Royal Hampshire Hospital, seven in July, 33 in August 2021, 17 in September and 15 in October 2021. 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

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. However, consultant obstetricians were on site from 8am to 5pm, Monday to Friday. There was a night handover at 7.30pm for midwifery and 8pm obstetric handover, 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 labour ward. 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

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

Women's notes were comprehensive, and all staff could access them easily. The majority of women's notes were stored on an electronic patient record and the rest were paper notes. Each healthcare professional who had contact with the women recorded their care in the electronic patient record.

The trust had recently implemented a new electronic patient records system. For women who had started their birthing journey prior to this, they also had paper records. We looked at five patient records on both the electronic and paper based systems.

Paper records were completed well and documented Carbon Monoxide screening, Whooley depression screen, VTE (Venous thromboembolism) risk assessment, Fetal movements, "fresh eyes" on CTG (*Cardiotocograph)* monitoring, customised growth charts, allergies and domestic violence questions. Neonatal observations were taken and documented at appropriate intervals. Antenatal appointments were well documented.

However, we saw one record that did not have the domestic violence question asked and one record that did not have the woman's birth care plan completed. Notes for babies were documented well, with blood, heart rate monitoring results and measurements all recorded.

Records were stored securely. Records were stored electronically, and the trust still had some paper records in use but staff advised these were becoming fewer. Paper records were stored in a ward office behind a closed door. Having both paper and electronic records may pose a risk to the safe treatment and quick access of records for women and babies.

Staff prescribed, administered and recorded pain relief accurately. This was not always done in the correct order due to unfamiliarity by some staff with the new Electronic Prescribing Medication Administration system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however some staff told us they had not been fully trained on the electronic system.

The trust had implemented a new electronic prescribing and medicines administration (EPMA) system at the beginning of November 2021. Staff told us paper drug administration charts are also in use and placed in patients paper notes but not always on the electronic system. This created potential a risk of missing or duplicating the administration of medications to women.

Staff reported the use of the EPMA system was hampered by slow running systems which meant they could not always access information quickly. Not all staff had received effective training on the EPMA and so relied on colleagues to show them how to use it. Staff access to training was sometimes hampered by clashing with shifts or annual leave, so it was not always easy for staff to attend training.

For example, we saw a member staff could not enter the pain relief medications a woman required onto the EPMA before administering it. A member of staff supported them to enter the information but was called away. The staff member tried to enter the medication details but was unable to do so. They then left the room to administer the medication and returned shortly and entered the information onto the system with support from another colleague.

We saw good practice of staff using "Do not disturb" tabards when on drug rounds.

Staff stored and managed all medicines and prescribing documents safely and in line with trust policy. We saw well documented fridge temperature records for two fridges used to store medicines. The medicines storage room had a keycode entry system, was clean, tidy and any clinical waste was in the correct bins.

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

Incidents

The service did not always manage safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents however, lessons learned were not always shared with the whole team and the wider service.

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

Learning from one incident was seen and changes in practice were implemented as a result. A mother had fallen asleep and dropped her baby. Staff alerted help using the emergency buzzer, the baby was sent to the neo natal unit, the mother was given a debrief by staff and supported well emotionally due to her distress. Changes to wards were made by information posters and bed curtains were kept open.

The service had a never event in August 2020 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.

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

Maternity

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.

Policies had clear indications at the start which referenced recent changes. Policies were dated when reviewed and there was an indication of the next review date.

There were protocols outlining how to share guidance with staff.

However, we noted the absence of specific guidelines for: Reduced Fetal Movements, Out of Hours Attendance for Consultants and Triage (BSOTS).

Staff told us that there were informal arrangements for out of hours consultant cover, and these arrangements worked well. We saw both MEOWS and 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. Staff were able to describe how they managed patients who may have additional needs in relation to their mental health.

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.

Maternity

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 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%, however, this was significantly higher than readmissions on the trust's other maternity site (1.6%).

Competent staff

The service generally 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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. However, staff told us they had been unable to practice live drills and pool evacuation recently as they were so short of staff. Staff could not tell us when the last baby abduction drill had been carried out. Trust data showed that no baby abduction training had been carried out since October 2020.

Trust data showed fetal monitoring training for doctors and midwives had a compliance of 43% for doctors and 26.5% for midwives. Low compliance rates were due to a change in the way the trust recorded training data and reflected a rolling-rate for annual compliance.

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.

The practice development team supported the learning and development needs of staff. There was no specific written policy for the support and supervision of midwives. All maternity staff, including midwives, had access to well-being services provided by the trust.

Maternity

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.

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.

Staff completed Practical Obstetric Multi-Professional Training (PROMPT). PROMPT training aims to reduce preventable harm in mothers and babies and includes skills workshops and drills to allow staff to work through scenarios together in a low pressure situation. Data submitted by the trust showed 234 midwives, 59 midwifery support workers and 29 medical staff had completed the training between January 2021 and October 2021. Trust data showed 100% compliance with PROMPT training for midwives and maternity support workers and 89% compliance for doctors.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw a handover between neonatal staff and transitional care staff. They reviewed women's notes and took verbal updates from transitional care staff. They also had an electronic handover system in place linked to the electronic patient record system, this helped to provide consistency for the handover.

Handovers on the labour ward followed a structured SBAR format (Situation, Background, Assessment and Recommendation). This ensured the equality and diversity; holistic and religious needs of women were discussed along with clinical needs.

Specialist midwives were able to support women with specific needs, for example breastfeeding.

Staff across the department worked well to ensure continuity of care if women were being moved from the midwife led unit to the labour ward. Discussions took place during handover that included women across the whole department including antenatal, post-natal and two low risk birth rooms. This ensured staff were aware of the team needed to support all the women. Staff referred women for mental health assessments when they showed signs of mental ill health including depression.

Consultant obstetricians were present onsite until 5pm and obstetric registrars were onsite 24 hours per day. There was an on-call rota for consultants and clinical advice could be sought over the telephone or the consultant would come to the hospital in person.

Is the service well-led?

Requires Improvement

Maternity

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. However, they were not always able to manage them effectively when working clinically. Local leaders were visible and approachable in the service for patients and staff although senior leaders were not always visible

Maternity was part of the Family and Clinical Support Services Division across Hampshire Hospitals NHS Trust. The head of midwifery was predominately based at the Basingstoke site but 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 Winchester site there was an inpatient matron and a community matron, and a governance and safety lead who reported into the deputy head of midwifery.

Staff told us the deputy head of midwifery at Winchester was visible and approachable in the service for patients and staff but the further senior leadership team could not be identified by many of the midwives and staff we spoke with.

The senior midwifery leaders in the unit were constantly trying to manage the staffing levels and frequently working clinically and undertaking many front-line roles. This showed support for staff but it meant they were not always able to undertake their leadership roles and safety oversight of the unit.

All staff spoke well of their immediate managers and leaders. Most staff felt supported, listened to, and felt able to raise concerns. Staff had approached leaders and raised serious concerns about behaviour and culture. These concerns were listened to and addressed which had significantly improved their confidence.

The leaders recognised that there was a significant pressure on the staff in the unit and had been making changes to start to address them. Not all staff were aware of these and updates were not cascaded formally.

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. The service were developing an open culture where patients, their families and staff could raise concerns without fear. However, staff said did not always feel that issues they raised were addressed.

All 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. During the inspection staff told us they worked in an improved and supportive culture since recent changes in leadership.

There was a multidisciplinary approach to the care delivery. Medical and midwifery staff spoke equally about working together to ensure safety and give a positive experience for mothers and babies. We saw examples where staff had felt able and supported to professionally challenge clinical decisions. This included junior members of staff. There was a good working relationship between midwives and doctors and the team communicated well and supported each other.

The maternity unit is in a separate building within the hospital campus. Senior leaders told us there was limited maternity representation at operational meetings at the Winchester site. They described not feeling connected to or part of the main hospital.

Maternity

Staff mostly told us the culture was one of learning, not blame. Staff were women focused and the midwives had helped support each other during the previous few months when staffing and leadership had been stretched. Staff had reported feeling “pushed to the limit” and “exhausted and demoralised”.

The trust had introduced a pilot Maternity Culture Change Project in 2021 to include trust wide culture change workstreams, behaviour frameworks, HR and management training and leadership training for maternity staff. This hopes to improve staff culture and wellbeing, training quality, career development and provide leadership skills.

Staff told us that previously they had felt there was no point in raising concerns because they had experience of issues not being addressed. Although more recently staff reported this had begun to improve.

Staff were aware there was a freedom to speak up guardian but none of the staff we spoke with had used them.

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 panel so had oversight of current issues and risks. Within the panel were midwives, obstetricians and, when required, specialists such as radiographers.

When incidents occurred, a case review was done within 48 hrs 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.

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.

There was recognition staffing numbers had an impact on the trusts ability to update guidelines and policies. This included an imbalance of generalist and specialist medical staff to help create new guidance and policies.

Leaders had various monthly meetings to discuss high risk care, fetal medicine, diabetic clinics, obstetric, consultant and anaesthetists meetings but these were not all a multi-disciplinary approach. However, some senior leaders could not always attend data review meetings as they clashed with clinical commitments.

Maternity

A newly formed Maternity Strategic Transformation Board had been set up to regularly review trust data but this was not yet been fully embedded.

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.

The trust recognises the need for more specialised clinics, clearer care pathways for patients and to develop staff specialisms but feel this is limited by time, staff and finances.

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.

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.

Outside of the pandemic leaders and staff actively and openly engaged with patients, staff, 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).

Maternity

The trust used a range of communication tools to aid learning and development. This included newsletters, emails, hot topics. However, staff said they did not always have time to read or engage in these methods of communication at work because they were prioritising clinical care. To mitigate this the service used closed social media and information sharing platforms to communicate key messages with staff.

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 service must ensure regular checks on emergency and essential equipment are carried out. (Regulation 12 (1)).
- The trust must ensure the Day Assessment Unit has an effective and working emergency call bell system to ensure the safety of patients in an emergency and the safety of staff who are lone working in that area. (Regulation 12(1) & 12(2)).
- 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 reflect risk. Regulation 17(1).
- 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 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 lead inspector, a second 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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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 17 HSCA (RA) Regulations 2014 Good governance