Care Quality Commission

Royal Surrey NHS Foundation Trust

Royal Surrey County Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Surrey County Hospital

Outstanding ☆ ➔➔

Pages 1 and 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Royal Surrey County Hospital.

We inspected the maternity service at Royal Surrey County 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.

The Royal Surrey County Hospital provides maternity services to the population of Guildford, Cranleigh, Farnham and surrounding areas.

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

Maternity services include an early pregnancy unit, maternal and fetal medicine, outpatient department, planned assessment unit, maternity triage, antenatal ward (St Catherines Ward), delivery suite (Consultant-led Birthing Suite), midwifery led birthing suite, two maternity theatres, postnatal ward (Shere Ward), enhanced care, ultrasound department and 6 maternity community hubs. Between October 2022 and September 2023, 2,977 babies were born at Royal Surrey County Hospital.

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.

During our quality assurance process we noted the location should have been rated as Outstanding since our previous inspection which was published in June 2020. Therefore our rating of this hospital stayed the same. We rated it as Outstanding.

We rated maternity services as Outstanding because we rated safe as Good and well-led as Outstanding.

How we carried out the inspection

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

We visited Maternity planned assessment unit, maternity triage, maternity theatre, recovery, enhanced care, delivery suite, birth centre, antenatal clinic, the antenatal and postnatal wards.

We spoke with 36 multidisciplinary staff, 4 women and birthing people and 1 birthing partner and or relatives. We received 5 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 7 patient care records, 7 Observation and escalation charts and 7 medicines records.

Our findings

Following our onsite inspection, we spoke with 6 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

Outstanding ☆ ➔➔

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

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women 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 and medical staff, planned and actual staffing numbers were equal to each other.
- Staff assessed risks to women and birthing people, acted on them and kept good care records.
- The service managed safety incidents well and learned lessons from them.
- Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders supported staff to develop their skills. Safe innovation was celebrated.
- The service had a strong vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all women and birthing people were seen in a timely way on arrival in triage.
- Staff did not always check controlled drugs regularly in line with the trust policy.
- Staff did not complete daily checks of milk fridge and freezer temperatures to ensure milk and colostrum were stored at a safe temperature to feed babies.

Is the service safe?

Good ● ➔➔

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

Mandatory training

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

Maternity

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocography (CTG) competency, manual handling, human factors, skills and drills training and neo-natal life support.

Ninety-three per cent of staff had completed all mandatory training courses against a trust target of 90%.

The service made sure that staff received multi-professional simulated obstetric emergency training (PROMPT). Records showed from October 2022 to September 2023, staff achieved an overall 94% compliance rate in their PROMPT training. We noted all multi-disciplinary staff group met the 90% trust target. Staff spoke positively about the PROMPT training and how it was fit for purpose and helped improve their skills and competency. Data provided by the trust showed 94% of staff had rated the content of their PROMPT training as excellent.

Ninety- five percent of staff had completed the resuscitation training and 99.3% had completed the medicines management training against the trust target of 90%.

The trust data also showed that 99% midwives and 98% of medical staff had completed the cardiotocograph (CTG) and human factors training as of 27 September 2023.

The service held regular emergency skills and drills for staff in the hospital and community hubs. Trust data showed that some of the skills and drills that had taken place in 2023 include emergency pool evacuation drill and baby abduction drill. Other planned skills and drills for October and November 2023 included emergency transfer from maternity assessment unit to delivery suite and the transfer of unconscious patient from the birth centre to delivery suite.

Midwives and maternity support workers were required to complete a maternity update day training which covered various topics such as bereavement care, home birth, restorative clinical supervision, triage and mental health. From October 2022 to September 2023, 98% of midwives and 94% of maternity support worker had completed their role specific maternity update modules. In the same period 91% of staff had completed manual handling training.

Training was up-to-date and reviewed regularly. Senior leaders submitted staff training compliance in CTG, emergency skills and human factors to the trust board monthly as part of the Perinatal Quality Surveillance tool and the Maternity Safety report.

There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Staff told us and we observed that each maternity areas had regular scheduled study days and training contents which were targeted to different maternity areas. Staff told us the trust prioritised staff training and they were given protected time to attend their mandatory training. Staff told us they were rarely redeployed to work on the ward when they had training booked.

The service held monthly student midwives' workshop for student midwives and each month workshop focused on different topics such as escalation, drug charts, risk assessment and preceptorship programme preparation.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Staff and senior leaders told us the trust provided and paid for the agency staff mandatory and maternity specific training to ensure there they were up to date with skills and competencies.

Specialist staff also received internal and external training specific for their role or areas of interest. For example, the smoking cessation staff had received training specific for their role. The trust data showed that smoking training for trainers training compliance was 100% as at June 2023. The smoking cessation staff that provided tobacco dependency interventions to women and birthing people had also attended a 2-day smoking cessation practitioner course and the National Centre for Smoking Cessation and Training (NCSCT).

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. Training records showed that midwifery staff had completed both safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Overall compliance rate for midwives on the Level 1-3 safeguarding adults and children training was 93.4% compliance and 91% for the medical staff. The midwives had achieved 97% overall compliance on the L3 adult and children training while the medical staff had achieved 78% compliance against the trust target of 90%. Senior staff told us the low compliance of medical staff was due to rescheduling of training due to strike actions to cover clinical work and rotation of junior doctors into the unit. The low compliance of medical staff training due to doctors' strike was discussed at various governance meetings and added to the risk register in August 2023. The service had plans to reschedule the cancelled training for the last quarter of the year to improve staff compliance. Following this inspection, the trust advised that there had been improvement in the medical staff compliance with this training. As of November 2023, the overall safeguarding level 1 to 3 compliance for medical staff was 93%. Also, the medical staff had achieved the trust 90% compliance for the level 3 safeguarding children training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Maternity

The service held regular safeguarding and mental health clinics to support women and birthing people with safeguarding and mental health concerns. The safeguarding and perinatal health midwives held daily ward rounds in the intrapartum areas and wards to provide support to staff, identify any risk and safety concerns. Staff told us the safeguarding midwives offered orientation to the unit and sexual violence awareness training for junior doctors.

Staff had access to a regular group or one to one safeguarding and restorative 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.

Maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, we observed some dust on a neonatal trolley, forceps and post-partum haemorrhage (PPH) trolley on the labour ward. This was escalated to senior staff and addressed immediately. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. From July to September 2023, the cleaning audit result showed 98.3% compliance. Areas of improvement in the audit was around dust and limescale on equipment and there were action plans to address this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. From June to August 2023, the overall compliance in the hand hygiene audit was 99.7%.

From June to August 2023, staff achieved 100% compliance in the bare below the elbow audit and 99.3% compliance in the infection prevention and control audit.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, there were gaps in the daily checks of equipment and emergency equipment.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

The service carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas. A ligature risk assessment was last carried out on 21 September 2023.

Staff generally carried out daily safety checks of specialist equipment. Records showed that the resuscitation equipment were checked daily except the antenatal ward where we noted 3 gaps in the month of September 2023. Following this inspection, the trust advised that the department had shared the learning regarding the importance of checks of all equipment in safety huddles and team meetings. The service had an ambition to implement a QR code system to support easier records of checking emergency equipment which will form part of the 2024/25 business planning.

On the postnatal ward we observed gaps in the daily checks of milk fridge and freezer temperature. For the month of September 2023, there were 7 missing entries in the milk freezer temperature checklist and 6 missing entries in the milk fridge temperature checks to ensure milk and colostrum were stored in the correct parameters and safe to feed babies.

The service had processes to ensure equipment was maintained and tested for electrical safety, demonstrating it was fit for purpose and safe for patient use. We saw that where electrical testing of equipment had been carried out and the equipment had passed the test across the maternity services. However, on labour ward we found 3 pumps which had not been serviced or electrical safety tested.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. The service had designated rooms used for counselling of women and breaking bad news in triage and antenatal clinic.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and in the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

Assessing and responding to risk

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

The service proactively carried out several relevant local and clinical risk assessment audits to assess and respond to risks to women and birthing people and outcomes were used to improve care and treatment and people’s outcomes.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff also used the Newborn Early Warning Trigger and Track (NEWTT) national tools to assess and identify deterioration in newborn babies. We reviewed 7 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a quarterly audit of 20 records to check they were fully completed and escalated appropriately. Data showed that staff achieved 98.3% compliance in the MEOWS audit and 93% in the NEWTT audit in the March 2023 audits.

The telephone triage line was effective at managing incoming calls, providing advice and liaising with the service to ensure appropriate information was available. The service included a dedicated telephone line outside of the trust, for access to a midwife 24 hours a day, for help and advice and referral to the appropriate maternity service. The trust was

part of the Local Maternity and Neonatal System (LMNS) for the design and delivery of the maternity telephone referral and triage line providing a single point of access for all maternity referrals in these areas. The aim was to make sure women and birthing people had access to the right care as soon as they contacted the service. The LMNS Maternity Referral staff triaged women and birthing people in line with the agreed LMNS triage pathway and concerns based on the information provided by them and then gave advice or recommended the person to attend hospital.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The service introduced a target wait time of no more than 15 minutes for initial assessment by a midwife in May 2023. The maternity triage waiting times review audit for September 2023 showed midwives reviewed 61% of women and birthing people within 15 minutes of arrival and 79% of women and birthing people within 30 minutes of arrival. The result showed 19% improvement in the number of women and birthing people reviewed within 15 minutes when compared to audits carried before May 2023. The overall waiting times for women and birthing people waiting to see an obstetrician within 60 minutes after a midwife had requested it was 55%. Seventy eight percent of women who waited over 60 minutes were then discharged home immediately after review. The triage waiting time was on the risk register and there were mitigations and plans to continue improving the waiting time of women and birthing people in triage. During the inspection, we noted that staff gave women and birthing people a triage prompt card which advised women on their prioritisation score and expected waiting time to be seen by a midwife and/or doctor. However, on our inspection we observed that midwives and doctors reviewed women in a timely manner and there was low acuity in triage during the inspection. Women and birthing people we spoke to told us they were seen in a timely manner during their current and previous visit to triage.

The service had an on-going triage quality improvement project and staff told us this had helped improve the timeliness and obstetric review over the months. To further support this, the service was putting a business case together for the triage unit to have 5 more maternity support workers to join the team and additional medical cover in the afternoons.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The March to August 2023 audit showed clear interpretation and management plans following a CTG in 95% of cases and staff did ‘fresh eyes’ at each hourly assessment in 89.2% of cases and at least 4 hourly reviews in 100% of cases. We noted improvement in compliance in recent months and staff had achieved over 91% compliance in the hourly fresh eye reviews in July and August 2023.

In the same period, the service carried out a combined fresh eye and fresh ears reviews where intermittent auscultation was undertaken. The result showed an overall 91% compliance in the number of maternal and fetal wellbeing fresh eyes and ears peer review. Staff achieved 100% compliance in July and July 2023.

From June to August 2023 audit, staff achieved 95% compliance in the World Health Organisation (WHO) surgical checklist audit. Areas of improvement related to the sign out standard audited.

The February 2023 managing complex pregnancy audit showed 98.6% overall compliance on all standards audited.

Maternity

From April to June 2023, the reduced fetal movement (RFM) audit result showed that 100% of women with reduced fetal movement had a computerised CTG. Also, 92% of women with recurrent episode of RFM had an ultrasound within 1 working day to assess fetal growth. An example was given of responding to increased risk for a pregnant person following multiple episodes of reduced fetal movements who was offered induction of labour at 38 plus 4 days gestation.

From April to June 2023, the management of diabetes in pregnancy audits showed that 100% of women with type 1 diabetes were offered continuous glucose monitoring (CGM) during pregnancy and received appropriate education of use of CGM.

In the same period, 99.2% women were recommended vitamin D and risk assessed for aspirin at booking appointment. Staff also achieved 99% compliance in the doppler assessments.

From April to June 2023 the reducing smoking in pregnancy audit showed an overall compliance rate of 93.2% on the standards audited. The result showed that 99% women were asked about their smoking status and 94.3% women and birthing people had carbon monoxide (CO) monitoring at booking and 99% at births. Areas of improvement were around CO level monitoring and smoking status at 35 and 36+ 6 weeks, which were slightly below the 90% target.

In the same period, 100% of women and birthing people with CO over 4ppm (parts per million) were offered referral to the in-house smoke free pregnancy service and 64.3% accepted the referral. Data showed that 68% of the women were supported by the in-house team and set a quit date and 91% of these women reached a 28-day quit date which was verified by CO reading. Also 50% of women had quit smoking by the time they were 35 to 36 plus 6 days pregnant. The service had an in-house free smoking service in place since November 2022 and started offering nicotine replacement therapy (NRT) since January 2023.

Staff also performed well on various risk assessment audits above the trust targets in assessments such as risk assessment for preterm birth at booking, fetal growth restriction, multiple pregnancy and management and fetal growth restriction.

The June 2022 maternity unit clinic audit was carried out to ascertain whether women were formally risk assessed at every antenatal contact they have with midwives and obstetrician. The result showed 90% of women had documented risk assessment at every antenatal contact during pregnancy and 99.2% had documented risk assessment on the electronic record from antenatal to postnatal period.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used the SBAR (Situation Background Assessment and Recommendation) algorithm in the initial intrapartum risk assessments and to update their colleagues and handover care throughout the unit and recorded this on the electronic patient records. Staff achieved 90% compliance in the February 2023 SBAR audit against the trust target of 90%.

Maternity

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had regular safety huddles to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person. Staff work collaboratively to understand and meet the range and complexity of people's needs.

We also observed the theatre safety briefing, which was well led by the theatre matron and attended by the full theatre team. The theatre team had developed their own surgical safety debrief checklist for emergency and elective cases which was comprehensive included risk assessments, checklist include safeguarding concerns and different checks to be completed by multi-disciplinary team (MDT) staff. Staff told us this checklist had been shared and now used by other NHS trusts.

The service provided transitional care for babies who required additional care.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge when this was required.

Leaders monitored waiting times and made sure women and birthing people could access emergency caesarean section when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure women did not stay longer than they needed to. Managers worked to keep the number of delayed or cancelled operations to a minimum. To further improve the access and flow in the maternity service, the service had recruited maternity service co-ordinators to work in the service from 7.30am to 6pm, 7 days a week. This was a new role and separate from the labour ward coordinator's role. The new role ensured the maternity service co-ordinators had a helicopter view of the access and flow of the maternity services.

There had been increase in the number of caesarean section rates in the units and the leadership team had a system in place for ensuring there were enough suitably qualified staff for planned and emergency caesarean sections. Previously the caesarean sections were carried out half day 5 days a week and the service had recently introduced twice a week full day list to meet demand and ensure safety of women and birthing people.

The service had employed 5 full time band 5 maternity nurses in May 2023 to support with the elective caesarean section list. Staff felt with the new process, they had an oversight on the number of caesarean sections due to be carried and had appropriate staff to cover the caesarean section list. Staff and senior staff told us they had few delays or cancellations of the caesarean section procedures, and this were monitored regularly. From 14 April 2023 to 26 September 2023, the service reported 31 cases of delayed caesarean section. The delays were mainly due to high clinical activity, high acuity on the special care baby unit, strike actions and emergency case.

The electronic patient record system had an interface with the laboratory which enabled staff to have quick access and review to the live laboratory blood result of women and birthing people. Women and birthing people also had access to their electronic laboratory blood result after it had been reviewed by staff.

Midwifery Staffing

Maternity

Staffing levels matched the planned numbers which ensured the safety of women and birthing people and babies. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave temporary staff a full induction and training.

Staffing levels matched the planned numbers to ensure the safety of women and birthing people and babies.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. From June to August 2023 there were 58 red flag incidents, which were mostly related to supernumerary status of shift leader, delay in care or induction of labour or missed care. Staff were redeployed to ensure safety following escalation.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 140.74 whole-time equivalent (WTE) midwives Band 3 to 8 compared to the funded staffing of 136.49WTE, a shortfall of 4.25 WTE staff. Following the inspection, the trust told us there had been further investment in the midwifery staffing since the January 2022 staffing workforce review. The trust reported an increase in maternity staffing to 150WTE band 3 to 8 maternity staffing from April to September 2023.

For the period of April to October 2023, 98% of women received one to one care during active labour in line with national guidance.

There was a supernumerary labour ward shift co-ordinator and maternity service co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The ward manager adjusted staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas and acuity. Specialist or community midwives were used for escalation to cover staffing. The service had 6 community hubs and staff told us the community hub and home birth team were protected and not part of escalation.

The number of midwives and healthcare assistants matched the planned numbers. From May to September 2023 the fill rate was 99% for midwifery staff, which was better than the trust 90% target.

The service had reducing vacancy rates and low turnover and sickness rates. From April to September 2023, the trust reported 0.96WTE sickness rate for the midwives and 2.34WTE sickness rate for the maternity support worker.

The September 2023 divisional triumvirate monthly executive meeting highlighted that the midwifery staffing had been fully recruited to with new starters to commence work in October and November 2023. The anticipated vacancy rate by end of October 2023 was 7.9WTE for band 5 and 6 midwives.

Staff spoke positively about how the retention midwife had positively recruited and retained 18 midwives, which included 8 internationally trained midwives. At the time of inspection, the service was further recruiting to the shortened nurse to midwife conversion programme. The service had also introduced the role of the maternity service co-ordinators to manage access and flows in the service and to ensure the labour ward co-coordinators worked supernumerary. The service had also recruited 5 maternity nurses to support with elective caesarean section due to increase in demand.

The service had employed 4 apprentice midwives who were progressing through programme.

The service had also invested and increase the number of staff supporting perinatal mental health and infant feeding. For example, the service had employed 10 breastfeeding support staff who supported with infant feeding.

The service had low rates of bank and agency staff. From April to August 2023, the service had 7% use of bank staff and 7% use of agency staff. Managers requested temporary staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Hospital data showed 94% of staff had completed their annual appraisal. A practice development team supported midwives. The team include 3 clinical practice development midwives, 1 international recruitment specialist clinical practice development midwife, 1 preceptee support midwife, 1 lead practice development maternity support worker and governance team administrator.

Managers made sure staff received any specialist training for their role. For example, midwives had received funding for specialist training including smoking cessation and they had provided support for two trainee advanced midwifery clinical practitioner and supported midwives to complete a professional midwifery advocate course.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. As of 31 August 2023, the medical staff sickness rate was 1.3% which was better than the trust target of 3%.

From September 2022 to August 2023, the overall turnover rate for medical staff was 1% which was similar to the trust target of 1%. We noted the service achieved a zero turnover rate in July and August 2023.

From September 2022 to August 2023, the average fill rate for medical staff in the maternity service was 107.2%. We noted that the fill rate was consistently above 105% in this period. Staff told us safe staffing levels were achieved using bank staff and activating the trust 'acting down policy.'

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction. The service had an induction pack in place for locum staff.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The anaesthetic rota was compliant with Anaesthesia Clinical Services Accreditation standard 1.7.2.1 and the maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward for elective and emergency caesarean sections.

The service always had a consultant on call during evenings and weekends. The service made sure there was a consultant on site from 8am to 8.30pm from Monday to Friday in the maternity service and 8am to 11am and 8pm to 9.15pm on weekends. On weekend, there was also an additional cover by the gynaecology team between 8am and 5.30pm. Out of hours, consultants managed the rest of the on-call cover from their home location which was within 30 minutes of the hospital site.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Data supplied by the trust showed there were 12.3 whole time equivalent (WTE) consultant obstetricians, 8 WTE registrars and 8 WTE senior house officers (SHO) working in the maternity service at the time of inspection. The vacancy rate at the time of inspection was 0.84 WTE for consultants, 3 WTE for registrar and 1 WTE for SHO. However, the service had appointed 3 new registrars and 1 SHO who were going through employment checks at the time of the inspection and were due to commence work in the coming weeks. Staff told us they had adequate number of consultants and the trust had further invested in 2WTE in the consultant rota and perinatal leadership to ensure adequate skill mix and support for middle and junior grade doctors.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a complete integrated digital maternity electronic record which was used by all clinical staff and accessible to women. Women and birthing people could view their maternity records including scan reports, personalised care plan, track their pregnancy journey, view their upcoming appointment as well as document on their electronic records on how they were feeling. We reviewed 7 records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use.

From 1 October 2022 to 1 March 2023, obstetric staff achieved an overall 100% compliance in the antenatal clinic obstetric care plan audit.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not check controlled drugs regularly.

Staff did not always check controlled drug stocks regularly in line with their policy. During inspection, we observed gaps in the checks of controlled drugs on the wards, delivery suite and maternity theatre. Following this inspection, the trust advised during the factual accuracy process that they had review their policy for checking controlled drugs in theatres when the maternity theatres was not in use and a new process had been agreed. All units across the maternity service now completed a daily check of controlled drugs and this will be audited weekly by managers.

Staff however followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 7 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up-to-date. Medicines records were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to take action if there was variation with the exception of theatre where we found 11 missing entries particularly at weekends from August to September 2023.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on the digital systems for the 7 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 3 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service reported 2 never events in the last 12 months. There was evidence that changes had been made following feedback. Staff explained and gave examples of changes in practice following never events and serious incidents. For example, the service had implemented a swab count boards in the delivery rooms and theatre following 2 never events

relating to retained swabs and tampons. Also, the service had improved its informed consent process following a co-production work with their legal team following a few incidents in relation to birth outside of guidance. Staff told us the new informed consent process and out of birth guidelines had been shared and implemented by other maternity services in their region.

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

Managers reviewed incidents on a regular basis to identify potential immediate actions. Incidents were reviewed regularly in a timely manner and there were no overdue serious incidents or incidents open over 60 days as at the time of inspection.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 6 serious incident investigations and 1 external thematic incident review report and found staff had involved women and birthing people and their families in the investigations. In all 6 investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Staff reported serious incidents clearly and in line with trust policy. The trust made 4 maternity neonatal safety investigation programme (MNSIP) referrals between April to September 2023, which related mostly to therapeutic cooling. We reviewed 3 reports which had been referred to and investigated by the Healthcare Safety Investigation Branch and noted the trust only had one safety recommendation. We saw evidence to change in practice following the external reviews. For example, the trust had moved to language line app on the computers and mobile devices following a safety recommendation around interpretation services.

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

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning with staff during handovers and governance meetings around the use CTG to monitor twin babies and leaders reminded staff of the importance of documenting the rationale when CTGs are discontinued. The trust had commissioned an external review of some maternity serious incident cases between April and June 2022 to ensure learning and timely investigation of the incidents. The report showed positive findings around record keeping, evidence of clear discussion and listening, use of interpreter, referral for obstetric review, clear plan of care, decision and informed choice. Recommendation following the review include review of home birth guideline and process, standardised the terminology for CTG, ensure CTG training and skills were mandatory and review escalation process on labour ward.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Learning from all maternity serious incidents and perinatal mortality reviews were shared within the division, the trust and the wider local maternity and neonatal system. We saw example of a newsletter shared with staff following a sepsis case review held 12 December 2022 which detailed the outcome and learning from the review.

Managers debriefed and supported staff after any serious incident or never event.

Maternity

Is the service well-led?

Outstanding ☆ ➔➔

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

Leadership

Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond and plans to manage them which were shared with staff. Leaders had the skills and abilities to run the service.

There was a clearly defined management and leadership structure. The hospital maternity leadership team consisted of a professional director of midwifery and paediatric nursing, a chief of service and an associate director of operations. They were supported daily by a head of midwifery, clinical directors, specialist midwives, matrons, ward managers, speciality managers and assistant speciality managers and team leaders.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The maternity senior leaders felt well supported by their managers, maternity safety champions and trust executive, such as the chief executive, to deliver their role effectively. They reported having regular appraisals from their managers as well as having regular meetings with the staff they managed.

The trust executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive directors. The executive and non-executive maternity safety champions visited and completed regular walk around of the maternity unit.

The service leaders told us they had good support and direct access to the trust board, and this worked very well. Staff told us the trust board took issues raised with them seriously and this were taken on board to drive improvement. We saw from the minutes of board meetings that the trust board had oversight of the maternity service performance and received presentations monthly on staff training, incidents and data included in a perinatal quality surveillance tool. The trust board also received regular updates on the progress to national maternity safety recommendations.

Service leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. Staff told us the trust and maternity leaders were interested in their career development and invested in staff. For example, staff had access to various coaching, mentoring, leadership and development programme such as the Florence Nightingale leadership course, management foundations development programme, specialty leadership course and rising band 6 and 7 leadership programmes. The band 6 and 7 had regular external leadership team building training and the band 7 staff had also attended an offsite

band 7 leadership training away day. The service also had a leadership apprenticeship programme for the maternity support worker to progress from band 2 to 4 in line with the Health Education England framework. The service had two trainee advanced midwifery clinical practitioners in post. Following this inspection, the trust advised that the service was one of the first maternity services in the region to develop this role in midwifery.

The senior leadership team had attended the perinatal network leadership training. One of the clinical directors had been supported to complete a leadership master's course. We noted that leaders and staff attend regular debriefing session as part of a perinatal leadership and culture work.

Vision and Strategy

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a strong vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

The service mission statement was to be a service that met the requirement of the key national drivers, providing safe innovation, personalised and co-produced care framework for women and families through pregnancy and childbirth. The four key areas of focus for the service were workforce, confident birth, 'quality improvement and learning' and 'improving equity, access and clinical outcome'.

The trust had a single delivery plan for the maternity and neonatal services which was implemented in 2023. This was a three-year plan for the delivery of maternity and neonatal services and had been developed to ensure care was safe, personalised, and more equitable. The plan focused on 4 areas: listening to and collaborating with women and families, 'growing, retaining and supporting the workforce', 'developing and sustaining a culture of safety, learning and support'. The plan also focused on the standards and structures that underpinned safer, more personalised and more equitable care.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. The service's 2022/23 strategy also focused on the 5-year plan for the maternity and neonatal service, NHS England's 3-year delivery plan for maternity and neonatal services, Clinical Negligence Scheme for Trusts (CNST) year 5 maternity safety actions and NHS 10-year plan. The strategy also focused on the Local Maternity and Neonatal System (LMNS) 5 year plan, partnership working with stakeholders, coproduction of service with the Maternity Voices Partnership (MVP) and staffing, recruitment and retention. The service was drafting a new maternity strategy which would be implemented by March 2025.

The vision, mission, philosophy, and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. At the time of the inspection, the maternity strategy was being reviewed so that it reflected the national changes and maternity agenda, and this strategy would be included within the trust clinical strategy.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Maternity

There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued**.** There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. Staff were highly positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. For example, several staff spoke positively about their line managers and the maternity leadership team and told us they listened and escalate staff concerns immediately to the maternity safety champions and trust board.

Staff were focused on the needs of women and birthing people receiving care. Staff and leaders were passionate about their role and worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Staff spoke positively about the safety culture, collaborative working, and supportive relationship between multi-disciplinary team (MDT). There were opportunities to learn together, challenge each other positively and staff said there was no hierarchy among MDT staff. Staff told us the service was safe and they would recommend the maternity unit to their families and friends. We heard positive comments about the culture of the service.

There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. Several junior and senior staff had been working at the trust for years and staff told us there was equal opportunity to progress in their career. We saw examples of staff who had progressed to a leadership role over the years from junior staff, student midwives, and support workers.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

Staff told us their safeguarding training was fit for purpose and had been updated to include LGBTQIA+, which had further improved their skills and competency to effectively safeguard and provide LGBTQIA+ patients with a positive, affirming, and equitable maternity service.

As part of tacking inequalities and improving the outcomes for women, birthing people and their families, the research, development & innovation department had conducted a series of community outreach events throughout the year. The team had engaged with members of the Surrey's ethnic minority ethnic communities, such as the Syrian, Kurdish, Pakistani and Nigerian populations. The group had discussed health and care research that related to these

communities and from the feedback received had identified the key areas that needed to be focussed on, and the potential barriers to increased engagement. The service had an inclusion midwife who had worked closely with the maternity and neonatal voices partnership (MNVP) and caseload midwives to provide support, feedback, and meet hard to reach community including the Gypsy Traveller community.

The service celebrated staff and team success and supported good staff practice through the maternity newsletters, monthly nomination cards, thank you cards, farm event and trust staff awards. The service had a trust wellbeing drop-in session for staff, protected daily team teatime wellbeing check in meeting huddles and staff breaks were organised at the beginning of each shift to ensure staff took their breaks to help promote wellbeing and prevent burn out. Staff also had access to restorative supervision and mental health first aid sessions to promote their wellbeing.

The maternity service and trust had a strong focus on culture and staff told us senior managers had been proactive in improving the culture of the service over the years through several initiatives. As a result, the culture had significantly improved among staff.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. All staff had access to 'Freedom to Speak Up Guardians' and champions.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service had taken part in the national 2023 NHS Staff Survey. Leaders had studied the findings and developing an action plan which was being monitored by the Board. The top 3 areas of improvement for the service were IT infrastructure, teamwork, and burnout. The service held number of staff debriefs and safety summit following the survey to get feedback to help develop an action plan and drive improvement. Senior staff told us that following learning from the debrief session, serious incidents, and safety summit events the maternity and neonatal safety champions had taken the decision to engage the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to provide a workshop in November 2023 with the aim to further strengthen the culture. The workshop was planned to focus on culture, professional behaviour and patient safety. The workshop was in the planning stage and the service aimed to complete this by end of 2023. Also, to further promote staff wellbeing and prevent staff burnout, the service was looking at carrying out the wellbeing drop-in sessions in the maternity units for the first time, which will help strengthen the accessibility for staff to these sessions.

To promote the wellbeing of women and birthing people, the service had placed mindful colouring books and boxes in the induction bay and antenatal ward for women to use whilst in the unit, which was therapeutic and helped enhanced their wellbeing and reduce anxiety.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting around complaints and feedback. From January to September 2023, the service received 6 complaints, which were mainly related to medicines, patient care, pain relief and treatment. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Maternity

Governance

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

There was a clearly defined governance structure that detailed the governance oversight and accountability from the service level to the trust board level. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Governance arrangements were proactively reviewed and reflected best practice. Leaders operated effective governance processes, throughout the service and with partner organisations. Governance and performance management arrangements were proactively reviewed and reflected best practice. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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

The service held various governance meetings which fed into the maternity quality committee and were reported to the trust board. This includes the monthly maternity quality and safety meetings, monthly maternity and neonatal safety champions meetings, weekly and monthly divisional triumvirate executive meetings and monthly safety champions meeting. Managers also attended local maternity system and neonatal network meetings, patient safety network meetings and the quality performance executive committee which fed into the trust board meeting.

Governance meeting agendas included discussion around all aspects of governance and oversight of the service such as performance data, audits, walk arounds, training, serious incidents and learning, feedback, safeguarding, policies and guidelines. Governance meetings were well attended with full multidisciplinary attendance, and actions were highlighted and reviewed at each meeting. Outcomes of governance meetings and service dashboards were shared with staff through emails, posters, handovers, staff closed social media pages and quarterly learning packs. Leaders also shared performance data and learning via various monthly newsletters such as clinical governance newsletter, delivery suite newsletter, birth and beyond newsletter and infant feeding newsletter.

We reviewed the trust board minutes which showed that maternity items were part of the monthly meeting papers and include topics such as serious incidents, staffing figures and fill rate, performance reports. The national maternity reports recommendations, performance data, Clinical Negligence Scheme for Trust safety action compliance (CNST) and the NHS staff survey were also reported to the trust board monthly. From the governance minutes reviewed, we noted that the maternity service had achieved full compliance against each of the 10 CNST standards. Staff and leaders, we spoke to were proud that the service had achieved CNST year on year.

Staff told us following an external regional assurance visit, the service had further strengthened the management of complex pregnancy by recruiting a maternal medicine specialist midwife who worked collaboratively with the maternal medicine consultants. Following recommendation from the assurance visit, the service was working closely with the LMNS on managing complex pregnancy pathways and wider maternal medicine pathways for a 3-year delivery plan.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. All 16 policies and guidelines reviewed during and after the inspection were clear and up to date. This was an improvement from the last inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits such as the Perinatal Mortality Surveillance report and the National Maternity & Perinatal Audit (MBRRACE). Staff were actively engaged in activities to monitor and improve quality and outcomes. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national and local standards. The trust was not an outlier on any national audits however the trust had high rates for third- and fourth-degree tears and fluctuating rates for women who had a postpartum haemorrhage (PPH) of 1,500mls or more when compared to the comparator group in the last 12 months. The service had quality improvement projects in place to improve the rates of PPH and third and 4th degree tears.

In the 2023 General Medical Council (GMC) 2023 survey, the service scored significantly above (better than) the national average for educational governance and scored similar to national average on 17 outcomes. The result of this year survey was better than the 2022 survey where the service scored below the national average on 2 outcomes. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a comprehensive programme of repeated local and national audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and feedback and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. For example, the service had improved processes to meet the increasing demand for planned caesarean sections and induction of labour in the service. The induction of labour ward was opened 24 hours 7 days a week to meet the increase in induction of labour rate with obstetric review cover available on each shift.

The service had a risk register which included risks such as obstetric training, triage witing times and staff exposure to medical gasses. All risks had identified mitigating actions and were reviewed regularly.

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

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

Maternity

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers also shared this with their local maternity systems and could benchmark performance with other hospitals within their network. Key information from the dashboard, audits and performance data were reported on the trust board papers and displayed across the service for staff, women, birthing people and public to access.

Data or notifications were consistently submitted to external organisations as required. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme, maternity dashboard and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff used electronic patient records which were password protected to access all the information they needed, this included screening results and safeguarding information.

The information systems were integrated and secure**.**

During inspection we observed staff protect patient identifiable information in line with General Data Protection Regulations (GDPR).

Data or notifications were consistently submitted to external organisations as required.

The service had launched a new maternity parent portal in September 2023 and information could be translated to over 100 languages and had contrast and accessibility features to meet the needs of people with visual impairments and/or needs. The portal provided women and birthing people with access to 48 clinical guidelines, a virtual tour of the maternity service, glossary of maternity terms and abbreviations on the portal. Women and birthing people could also access 117 patient information leaflets on their electronic patient record app.

Engagement

There were consistently high levels of constructive engagement with staff and people who used services, including all equality groups. They used innovative approaches to gather feedback from people who use services and the public, including people in different equality groups, and there was a demonstrated commitment to acting on feedback. They actively collaborated with partner organisations to help improve services for women and birthing people.

Services were developed with the full participation of those who use them, staff and external partners as equal partners. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Service leaders had built meaningful relationships with the MVP and encouraged them to attend meetings on site, such as the governance committee meetings and maternity safety summit. The MNVP were passionate about their role, had regular engagement with leaders to make a difference to services provided to women and birthing partners who accessed the service. The MNVP had regular meetings with the trust and easy access to the senior leadership team to escalate any concerns promptly.

Maternity

The MNVP were involved with recruitment update, coproduction work such as midwife advice line information leaflet and baby loss leaflets. They had worked with the hospital patient advice and liaison service (PALS) to obtain feedback from women, birthing people and their families about care of babies with Down's syndrome. At the time of inspection, the MVP group were working with the practice education lead to ensure women and birthing people voices were embedded in staff training and development to drive improvement.

The MNVP held regular listening events, social media live events, engagement meetings and focus groups with different communities' representatives such as the Muslim community and autism support groups. The MNVP had also established links with representatives and ambassadors from ethnic minority groups and deprived communities to get their feedback to drive improvement. For example, the MNVP had involved the MVNP ambassadors for ethnic minorities, Surrey minority ethnic forums and other service users in a '15 steps challenge' designed to assess first impressions of the service, which was carried out in March 2023.

The MNVP also engaged with charities and external organisations to address inequalities and improve the experience and outcomes of women, birthing people and families that accessed the service. The MNVP had an annual work plan, and we noted that some of the actions had been completed. This included an 'Always ever event for infant feeding and induction of labour, review of maternity website and microsite and information leaflet. The MVP had also completed the coproduction to develop personalised care plan and recruiting an ambassador for mental health and infant feeding. The other action plan that was in progress include establishing further links with ethnic minority groups and representatives from and areas of deprivation.

The MNVP was involved in quality improvement project around public health and review of cases around induction of labour and autism. The service and MNVP also engaged women and the public using social media and their websites. The service engaged with and received feedback from women and birthing people during ward rounds, birth reflection meeting, whose shoes workshop (transformation engagement tool) and face to face resolutions following a complaint received.

Leaders understood the needs of the local population and knew their demographics. Following feedback from their neuro diverse community in March 2023 around signage in the service, the leaders had worked with the MNVP to create a video of how to find the different maternity units and how each maternity areas looked like.

Hospital data showed that 65% of women and birthing people were on the continuity of care pathway, of which 50 to 60% of women were from ethnic minorities and socially deprived backgrounds. The service had plans to increase the continuity of care provision to 85% in future when staffing was fully established.

We noted the service actively worked to address inequalities and meet the individual needs of their population through various ongoing work such as transportation cost to attend hospital appointments. The service had worked collaboratively with the local council, MNVP, maternity safety champions and primary care service to provide support to the asylum seekers in the community and hotels. The service had a patient experience midwife that focused on engagement and getting feedback from staff, women, birthing people and their families to improve the patient experience and drive improvement. Following feedback from a Gypsy Traveller community member around their preferred mode of communication due to high cost of living, the service had introduced the use of a social media voice note as a mode of communication for women and birthing people. Staff felt the trust was getting better at closing the loop from staff and patient feedback and using this to drive learning and improvement. The perinatal mental health midwives had engaged and provide emotional support to women, birthing people and their families that lived in a remote village and felt isolated and dealing with anxiety.

Maternity

Managers engaged with staff through various ward and staff meetings, safety pin (message) of the week, social media live event with the director of midwifery, 'you said we did' posters, forums, listening events and newsletters. The division held a division wide anonymous staff survey, and the results was discussed at the quality and safety meeting and the maternity and neonatal safety meeting. Results of feedback from all sources were fed back to staff via the 'Ask me anything forum', via the safety dashboard posters, listening service ward round newsletter and in the clinical governance newsletter. The August 2023 infant feeding team newsletter highlighted that 78% of women felt very happy about the overall infant feeding care received and 81% felt staff were kind and considerate.

The director of midwifery and student lead continuing professional development midwife held jointly quarterly forums for the student midwives. The director of midwifery held a monthly staff forum with representatives from the Royal College of Midwifery and each staff group to obtain feedback, discuss issues and obtain suggestions.

We saw examples of improvements made to the service from the 'You said - we did' posters following feedback from staff. This included on-going support and staffing plan for agency midwives, review of hypotension in pregnancy guidelines and collaboration with a catering solution provider to improve the food offered to women and birthing people with diabetes in the service.

Staff told us that the practice development midwife had regular tea trolley rounds on the wards to engage with staff and share the governance and learning with staff.

The bereavement midwife engaged with national and local bereavement charities to support services for women, birthing people and their families. This included engagement with a charity to support the development of a bereavement book. Following the inspection, the trust advised that the bereavement midwife had also engaged with a charity to provide additional bereavement training for maternity staff to improve their skills and the outcomes for women, birthing people and their families.

The Obstetrics and gynaecology 2023 staff survey result showed improvement from previous years on all standards. The service had an action plan in place to address the areas of improvements, which were staff morale, training and learning and health and safety. Some of the actions include implementing a team tea wellbeing check in meeting huddles without agenda to encourage staff to take breaks and staff should receive payment or time in lieu for overtime hours. We noted that these actions had or were being implemented at the time of inspection.

In the 2022 CQC Maternity Survey, the trust scored about the same for 36 questions, 'Much better, better & somewhat better than expected' for 13 questions and 'somewhat worse and worse than expected' for 2 questions. The result also showed that the trust had a response rate of 57% which was better than the national average of 47%. We note that the trust scored 'worse' or 'somewhat worse' than average on involvement in the decision around induction of labour (IOL) and giving relevant information around risk of provision of IOL. Following the survey, the service implemented a quality improvement programme on the IOL and developed an induction of labour toolkit which included videos, handouts and practical tips around induction of labour. Staff told us the service was the trailblazer for their digital work in the implementing of an induction of labour toolkit and this would be shared across the region.

Feedback from women, birthing people and their partners we spoke to during inspection was positive about the care and communication by the service. We received approximately 5 responses to our 'give feedback on care posters' which were on display during the inspection. Of these responses all were mixed feedback however the majority of the comments were positive. Themes from the positive feedback related to care received, support, breastfeeding support, electronic record. Negative comments or suggestions of improvement mainly related to communication and staff attitude.

Maternity

The service always made available interpreting services for women and birthing people and collected data on ethnicity.

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. Safe innovation was celebrated. There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

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

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Quality improvement (QI) was routinely discussed at quality improvement meetings and governance meetings. Examples of QI projects that were completed or in progress included antenatal triage service, first hour of life and review of accessibility of clinical guidelines with QR codes published and available in clinical areas.

The maternity service had achieved the final UNICEF baby friendly gold status, which is considered gold standard to improve the infant feeding and relationship building experience of mothers and babies. The trust was one of 18 NHS trusts in the UK to be awarded a gold status and staff were proud that they had worked hard to maintain this status over the years. We noted the service provided breastfeeding support and helpline for babies up to 6 months of age, which is considered exemplary.

The maternity services team won a maternity and midwifery initiative of the year award for their patient-led service development, ‘Hearing the True Voice of Women project. The team’s entry looked at the department’s feedback methodologies and how the team tackled the issue of the previous limitations in fairly representing all women by adopting the use of a patient experience platform to support a transformation within the maternity service. The team was led by the transformation lead midwife and the team were involved in developing new maternity hubs in local communities and setting up assigned small teams of midwives to see women through pregnancy and birth, it was keen to gather feedback to further develop its services.

A collaboration between the hospital Surrey Crisis Resource Management (SCReaM) Team and Maternity Services has also been shortlisted for a further Health Services Journal Patient Safety Award for the Maternity and Midwifery Initiative of the Year category. The maternity team had collaborated with the SCReaM Team’s, who managed the hospital human factors management programme to work on the TEACUP project which looked at effective communication and collaboration within multi-disciplinary teams to promote wellbeing and ensure staff could escalate concerns to provide the best possible maternity care for women and birthing people. The feedback received as part of the project during the pandemic, highlighted women’s worries about coming into hospital for antenatal appointments. This led to the team setting up of drive-through routine antenatal checks and online antenatal classes. The feedback was also used to inform the design and content of the maternity microsite.

Maternity

The human factor and team resource management programme team who delivered the human factor training were shortlisted in 2022 for the patient safety education and training award.

The service had a hotel pilot project which had supported 10 pregnant refugee and asylum seeker women lodged in a local hotel with transportation fees to the hospital for their appointment. Staff told us this had helped address the missed appointments due to the difficulty some of the women faced in getting to appointment due to transport fare and cost of living.

The maternity service had received a regional award for the midwives' support for the initial case loading of 15 vulnerable women at any one time in an accommodation hotel and tracking down women that had been moved over night to another region. The case load midwives had ensured proper handover were giving to the new team the women were relocated to and had used interpretation service during assessment and provision of care.

The service held regular educational antenatal workshop programme for first time parents and the parent education series had been published in April and May 2023 in a top UK midwifery journal.

The clinical skills facilitator had won an award from a local university for going above and beyond to support student midwives in practice.

The bereavement midwife had co-produced a bereavement leaflet for bereaved families with the support of 2 bereaved mothers. The leaflet had led to the co-production of a bereavement book to offer practical advice, support and stories for bereaved women and families that had experience baby loss. The bereavement book is a collection of personal stories from bereaved parents and grandparents suffering different types of baby loss and had been published with support from a bereavement charity and launched the baby loss awareness week. At the time of inspection, the book was being rolled out nationally for professionals across different NHS trusts to order for free for their patients and bereavement suites.

Outstanding practice

We found the following outstanding practice:

- The service was nominated for several awards around patient safety and tacking health inequalities and won the maternity and midwifery initiative of the year award for their patient-led service development, 'Hearing the True Voice of Women' project.
- The service and the maternity and neonatal voices partnership (MNVP) working together was exemplary, active, and engaged well with the service to drive improvement, service delivery, co-produced leaflets and involved in quality improvement projects.
- The bereavement midwife engaged with a charity to support the development of a bereavement book and also engaged with a charity to provide additional bereavement training for maternity staff to improve their skills and the outcomes for women, birthing people and their families.
- The service had developed a new maternity parent portal which allowed women and birthing people to access clinical guidelines, patient information leaflets and a virtual tour of the maternity service.

Maternity

Areas for improvement

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

Action the trust SHOULD take to improve:

- The service should continue to improve the waiting times of women and birthing waiting to be reviewed by midwives and doctors.
- The service should ensure the milk fridge and freezer temperatures are monitored and recorded in line with trust policy.
- The service should ensure staff complete daily checks of emergency equipment and all equipment is regularly serviced.
- The service should consider reviewing the controlled drugs policy and ensure staff completed regular checks of controlled drugs in line with the trust policy.

Our inspection team

The team that inspected the service comprised a CQC lead inspector1 other CQC inspector, an Obstetric Consultant and two midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.