## Frimley Health NHS Foundation Trust

# Frimley Park Hospital

**Inspection report**

Portsmouth Road
Frimley
Camberley
GU16 7UJ
Tel: 01276604604
www.frimleypark.nhs.uk

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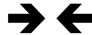
## Ratings

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

# Our findings

## Overall summary of services at Frimley Park Hospital

**Outstanding** 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Frimley Park Hospital.

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

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

We carried out a short-notice announced, focused inspection of the maternity service, looking only at the safe and well-led key questions. We last carried out a comprehensive inspection of the maternity service in 2019. The service was judged to be Good overall.

We did not rate this location at this inspection. The ratings for this inspection did not affect the overall location rating. This location was rated Outstanding overall.

We also inspected 1 other maternity service run by Frimley Health NHS Foundation Trust at a different location. Our report is here:

Wexham Park Hospital - https://www.cqc.org.uk/location/RDU50

### How we carried out the inspection

We inspected the service using a site visit where we observed care on the wards, spoke with staff, managers, and service users, and attended meetings. We interviewed leaders and members of the executive team remotely after the site visit. We looked at online feedback from staff and service users submitted via the CQC enquiries process. The service submitted data and evidence of their performance after the inspection which was analysed and reviewed for use in the report.

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

# Maternity

**Good**

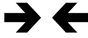
Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. The service had implemented temporary data-tracking systems and processes to ensure continued oversight of the service whilst awaiting full IT capability to come into effect. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services continually.

However:

- Not all staff completed mandatory training or had annual appraisals of their work. Some environments and equipment were dusty or out of date. Daily checks were not always completed, including a safety check of controlled drugs. Handovers were not always conducted in a standardised way and were interrupted unnecessarily. Babies' observation charts were not used effectively and there was a lack of a 'track and trigger' system to alert staff to deteriorating patients.
- Implementation of a new end-to-end IT system in June 2022 had meant accurate data extraction and audits could not take place effectively. The service did not have access to a live maternity dashboard to monitor performance indicators.

## Is the service safe?

**Requires Improvement** 

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

### Mandatory training

**The service provided mandatory training in key skills to all staff however, not everyone completed it.**

Medical staff did not always receive or keep up-to-date with their mandatory training. Compliance rates for medical staff were below the trust target rate of 90% in 12 out of 24 modules including: blood transfusion 81%, emergency planning 88%, fetal monitoring 73%, Gap and Grow competency 59% and Gap and Grow e-learning 71%, multi-disciplinary obstetric emergency training 83% and others. During the factual accuracy process, the trust said it had set compliance target rates to 85%.

# Maternity

Safeguarding training rates were low and did not meet the trust target rate of 90%. Doctors' adult safeguarding training rate was 75.6% and the maternity training rate was 82.5%. Doctors' child safeguarding training rate was 69.2% however, 99.5% of midwifery and support staff had completed the training which met the trust target. Service leaders had an action plan in place to achieve full compliance by June 2023 and during the factual accuracy process, the service said all staff received safeguarding training as part of their induction and on annual update days.

Compliance rates for pool evacuation training were below the trust target of 90%. Data submitted by the service showed 77.5% of staff had completed it. The impact of this was a potential delay, or unsafe evacuation from the pool in an emergency. Not all staff that we spoke to on inspection were able to safely describe the process of pool evacuation in an emergency or locate the necessary equipment. We raised this with managers on the day of inspection and they told us training was provided within 24 hours. Leaders told us 100% of labour ward co-ordinators had completed training and could assist in an emergency. During the factual accuracy process, the service said pool evacuation training commenced in April 2023 and there was a trajectory to achieve 100% compliance by April 2024.

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Maternity staff received and kept up-to-date with their mandatory training. We saw data that showed compliance rates above the trust target of 90% in all mandatory training modules except 'Gap and Grow' at 84% and Equality and Diversity at 87%.

Midwives and doctors completed cardiotocograph (CTG, or continuous fetal monitoring done in labour) training and there were annual competency assessments. The trust provided a full day's training for staff each year. Data submitted by the trust showed 213 out of 217 staff had passed competency assessments at the time of inspection. The staff who had not passed the assessment had action plans in place.

Staff completed adult resuscitation training and compliance rates were above 92% which met the trust target.

The lead for maternity practice development worked cross site between the two locations. The maternity service had a large practice development team which included lead midwives for recruitment and retention, practice development for staff and for students, clinical skills facilitators, a lead international midwife and lead fetal monitoring midwife; the team was supported by a practice development administrator. Staff and students spoke highly of the team and felt well supported.

### Safeguarding

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

Safeguarding training was provided in-house by the trust and had input from both the safeguarding and mental health leads. There was guidance in place for training and training was online and face to face, and included several key topics.

Safeguarding children's training included child exploitation, mental health, female genital mutilation (FGM), concealed pregnancy, domestic violence, and a bruising protocol. Safeguarding adults training included understanding of mental capacity act, deprivation of liberty, types of abuse, modern day slavery and domestic violence.

# Maternity

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. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients 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 knew how to make a safeguarding referral and who to inform if they had concerns.

Staff asked women and birthing people about domestic abuse. Where safeguarding concerns were identified, birth plans were put in place which were co-produced with the safeguarding team. Patient records detailed where safeguarding concerns had been escalated in line with local procedures. However, staff told us that documentation to produce detailed chronologies in safeguarding cases could be improved.

Staff followed the baby abduction policy and the service undertook baby abduction drills. The policy was issued in January 2023 and staff were able to describe the baby abduction policy to us. During our inspection we saw ward areas were secure and doors were monitored. Staff had been part of the baby abduction drill and gave positive feedback.

There was not a specific maternity ligature risk assessment in place, the service used a trust ligature assessment as required. However, the maternity service had liaised with a local mental health trust to support the service to produce a maternity specific risk assessment.

### Cleanliness, infection control and hygiene

**The service controlled infection risk. Staff used equipment and control measures to protect women, themselves, and others from infection. Equipment and the premises was not always visibly clean.**

The service generally performed well for cleanliness. The service submitted cleaning audits from February 2023 to April 2023 which showed consistent scores of over 99% which met the trust target. However, there were some areas where wards had failed cleaning, for example floors and low-level surfaces, and some dusty equipment was noted. The service submitted action plans that showed these failures were rectified on the day of audit. On the day of inspection wards and general areas in the maternity unit were tidy and well maintained however, we found areas where cleaning checks were incomplete, 'clean stickers' were not routinely used, and there was areas of dust. We escalated this to staff and there were cleaners present during the inspection.

Infection risks were controlled well. Staff kept equipment clean, and there were processes in place to maintain infection prevention and control measures when birth pools had been used. There was a process in place for Legionella checks.

We asked the service to provide infection prevention and control audits from the most recent 3 months and this was not provided however, the service provided old audit results from April and May 2022 which showed localised areas of poor compliance but scored 85% overall compliance with met the trust target of 85%. Areas of non-compliance had action plans completed and issues resolved. It was not clear if infection prevention and control audits had been done more recently than this.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

# Maternity

### Environment and equipment

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

Staff mostly carried out daily safety checks of specialist equipment. We found some checks on emergency equipment throughout the unit were missing, and daily checks were not always completed. The service used an electronic kit-checking system and staff told us that problems with accessing the system may mean that checks are not always logged appropriately. We escalated this to managers during the inspection and they told us they would ensure all staff members could access the system when required.

We saw that compliance on resuscitation equipment was 70-90% on the antenatal ward, and this was being audited to drive improvement. During the inspection we found some portable appliance testing on electrical equipment was due, and resuscitation trolleys were dusty. Some resuscitation trolleys contained expired equipment, we escalated this to staff immediately for replacement.

The design of the environment followed national guidance. The midwifery led birthing unit was located alongside the labour ward. All areas of the maternity unit were clean however, some areas were small as estates were aging, and staff and managers told us that it was sometimes difficult to move around and accommodate necessary equipment.

Staff told us the estates were becoming too small for the amount of activity and patients accessing the service, and there was difficulty in accommodating enough clinics, scanning, or meeting rooms to run the service optimally.

On the postnatal ward, the entry and exit was not visible to staff and this posed a risk of tailgating which had not been mitigated. However, doors on the maternity unit were locked; there was an electronic access system for staff, patients and visitors gained access using an intercom system.

Staff told us that the fast-bleep service which was used to call doctors did not always work, and this has been commented on elsewhere in the report.

The service offered aromatherapy to women and birthing people however we found that oils were not maintained according to the service policy, and we found some oils were out of date by over a year.

Inductions of labour took place on the antenatal ward. Babies requiring extra care were looked after under a transitional care pathway, and there were specific bays for them within the postnatal ward.

Store cupboards were clean, tidy, and uncluttered. The service had enough suitable equipment to help them to safely care for women, birthing people, and babies. Staff checked birth pool cleanliness and the service had a contract for legionella testing of the water.

The service had worked with women and the maternity voices partnership to develop birth boxes to improve the experiences of women and birthing people who laboured or gave birth in high-risk settings. All rooms on labour and antenatal wards had a birth box filled with items to support women and birthing people to have a calm and positive birthing experience. Boxes contained for example, fairy lights, birthing beads, stress balls, and anti-sickness bracelets.

Equipment such as birthing balls, aromatherapy, and knee pads were also available.

# Maternity

There was not a specific maternity ligature risk assessment in place, the service used a trust ligature assessment. However, the maternity service had liaised with a local mental health trust to support the service to produce a maternity specific risk assessment.

## 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 acted upon women at risk of deterioration.**

The labour ward was staffed with a supernumerary shift leader to support staff with clinical advice, escalate, and run the ward. However, there was no supernumerary unit co-ordinator with a 'helicopter view' of the whole unit to monitor acuity and maintain the safest levels and distribution of staff. Staff we spoke to told us trying to combine an overview of the maternity unit as well as their work on labour ward was stressful and may impact on safe completion of tasks. Staff told us there was a manager on-call system for support when needed, and that help was more readily available during the daytimes, but the service was isolated at night-times. Staff did not routinely access trust-wide support systems or know about them during times of high acuity. The service used an acuity tool to monitor and maintain safe staffing within the unit. During the factual accuracy process, the service said 3 matrons provided a helicopter view across the unit in hours, and they met a minimum of twice a day to carry out staffing and acuity huddles. The service said an on-call manager is always available out of hours.

The trust was currently reviewing an improvement workstream to monitor and audit the vital sign charts for babies, NEWTT (Newborn Early Warning Trigger and Track). The service currently had in place a live vital signs chart for babies, however, the track and trigger system required further development within the electronic recording system. This meant there was a potential impact on staff ability to recognise and escalate deteriorating babies. The service had added the NEWTT system onto the electronic patient records safety board risk register.

The service used a 24-hour telephone triage line for maternity queries and labour advice which was staffed by midwives within the local ambulance call-handling hub. This meant women had access to professional advice at any time of the day or night to ensure safe care. The service monitored call numbers and waiting times. Data showed a monthly average call rate of 2681 for both Frimley Park and Wexham Park hospitals between January and March 2023, and 73% of these calls were answered within 60 seconds. Data collected between January 2023 and May 2023 showed 15% of calls were abandoned by the caller and these were reviewed on a weekly basis. The service did not receive any complaints or safety concerns about the telephone line during this time.

The maternity triage service was located on the labour ward and staff had access to a SHO level doctor who was supported by the labour ward doctor. The impact of this was potential delays in care for higher risk women and birthing people whilst awaiting review by a senior doctor. However, during the factual accuracy process, the service said if labour ward doctors were unable to see women and birthing people in the required timeframe, staff could contact the gynaecology on-call doctor to ensure safety was maintained. Since March 2023, women and birthing people were risk assessed using a standardised tool and care was prioritised safely according to clinical need. There was an up-to-date guideline in place, and managers audited wait times to ensure safe care. The service shared data from March 2023 that showed 84% of women and birthing people were triaged within 15 minutes of arrival. Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

Managers had recognised that capacity to complete caesarean sections was sometimes a risk within maternity services. The service was speaking to staff to manage the risk as safely as possible by looking at medical rotas and educating staff. During the inspection we saw one caesarean section case needed to be delayed and the service had effective systems in place for this.

# Maternity

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets.

Staff completed risk assessments for each woman on admission and arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The service set a target of 100% for 1-to-1 care in labour. The average rate of 1-to-1 care in labour between January 2023 and May 2023 was 100% over the labour ward and the birth centre. We saw evidence of action planning to ensure targets were achieved and sustained long-term.

Staff used maternal obstetric early warning score (MEOWS) charts to record observations and recognise deterioration. Managers audited the use of MEOWS charts and identified areas for improvement using rolling quarterly audits. Staff told us that the IT system gave them a proforma to record observations, but this had recently changed to be reflective of a genuine MEOWS chart; before the change, the proforma did not function in the same way. Staff told us that the electronic MEOWS charts mostly worked well however, there were times when the system flagged up recordings as abnormal incorrectly, or vice versa, and this sometimes impacted on documentation and clinical decision making. Staff were aware of this issue, and there were reference copies of MEOWS charts available on the unit.

Shift changes and handovers in maternity areas included all necessary key information to keep women, birthing people, and babies safe. There was a multi-disciplinary handover twice a day on the labour ward in line with national recommendations. However, the format of the handover was disorganised, and did not follow a standardised approach, which may lead to information being missed. Lessons learnt were shared at daily safety huddles however, not all staff members were available at the later time when these meetings were held, which meant that key team members missed communications. We saw that handovers and huddles were not fully embedded into practice, were held in areas where there was disruption and noise, and were frequently interrupted. We escalated this to managers on the day of inspection and they told us work would be done to ensure these handovers were improved.

Each area of the maternity unit had a team handover twice a day to ensure all staff were up to date with key information, and individual staff had handovers regarding specific patients. The service used the IT system to complete individual handovers in a format which described the situation, background, assessment, and recommendation (SBAR) for each patient, and managers audited its use. Cross-site audit results for Quarter 4 2022/23 showed 68% of SBAR forms were completed in full and the remaining 32% were completed partially. There was an action plan in place for this.

### Midwifery Staffing

**The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

The service had enough nursing and midwifery staff to keep women and babies safe. Managers monitored staffing levels and 'red flag' events (a sign that there may be a problem with maternity staffing levels for example, delayed induction of labour). Managers audited the provision of 1-to-1 care in labour and had put actions in place to ensure this in 2021. Audits throughout 2022 showed women and birthing people had one-to-one care in labour 99% of the time.

# Maternity

The service had reducing vacancy rates and had recently recruited 45 maternity staff cross-site as of March 2023. The service had a vacancy of 30 whole-time equivalent midwives however, not all new recruits were actively in-post, and were due to start work during 2023 to further alleviate staffing pressures. Managers told us the vacancy rate was due to recent uplift in their funded staff quota however, staff told us that staffing remained an issue impacting their daily work, and staffing was the highest risk on the maternity risk register.

The service was reliant on bank staff to ensure safe staffing in the unit. Managers requested staff familiar with the service and made sure all bank staff had a full induction and understood the service.

The service had reducing sickness rates. Between January 2022 and May 2023, overall midwifery staff sickness rates had reduced from 7% to 3%.

The service had a recruitment and retention midwife who worked cross-site. They worked with matrons and midwives to review what improvements could be put in place to support with retaining staff. The lead completed all exit interviews with staff leavers to collate themes and to determine staff turnover.

Managers supported staff to develop through yearly, constructive appraisals of their work and 91% of maternity staff had received these on time, which was above the trust target rate of 90%.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers 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 babies safe. There was consultant cover on the labour ward from 8.30am until 8.30pm daily, and consultants were resident on the labour ward from 8.30pm until 8.30am during the week, and on-call during weekend night-times, which was above the recommendation for a unit this size. Doctors gave positive feedback about their rotas, and rota formation meant there was always consultant cover for the labour ward even if staff were sick or on leave. However, to achieve this, consultants covering labour ward were removed from any other duties such as clinics, which meant that clinic lists were cancelled.

Leaders told us that sometimes there was no consultant cover for elective caesarean lists however there was an experienced specialist trainee available to complete these, and managing the lists was an important part of training and development. Staff told us this sometimes put extra pressure on them. Leaders told us that there were sometimes gaps in the rota for specialist trainees due to maternity leave and other reasons, and that long-term, regular locums were used to cover the service in these instances to ensure doctors were familiar with the service. Staff told us that consultants sometimes acted down to fill the junior doctors' rota when needed and this may impact on staff wellbeing.

There was 132 hours per week of consultant presence on the labour ward. These hours were included in consultant job plans as direct clinical care. The consultant for labour ward had cover built in to cover holiday and other leave.

The twilight consultant took over care of the labour ward at 5pm until 8.30pm, so they were able to take part in the safety handover. The consultant then became the non-resident consultant who covered the obstetrics and gynaecology unit from home until 8.30am the next day. On Friday, Saturday and Sunday nights, there were 2 registrars and an SHO doctor on the labour ward alongside the resident consultant.

Monday to Friday, the daytime consultant worked 8am to 5pm. If the consultant was on leave, the shift was then covered by the consultant who was rostered to be on the labour ward cover week, the rota was 1 in 20. Consultants rostered for the labour ward cover week worked any labour ward sessions where consultants were on leave.

Managers made sure locums had a full induction to the service before they started work. There was a local induction checklist for locum staff. The checklist included an introduction to the department, working practices and procedures, clinical and ward-based protocols.

There was a clear process for the admitting consultant or consultant of the week to follow to make sure the locum doctor was supported and had a clear understanding of their role.

Sickness rates for medical staff fluctuated in 2022 and in December 2022 the rate was 4.9%.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. At the time of inspection there were 8 medical staff overdue appraisals, and the compliance rate was 75% which was below the trust target rate of 90%. In a group of 12 specialist obstetric doctors, 11 had had appraisals which was above the trust target. During the factual accuracy process, the service said 5 out of 8 staff due appraisals had them completed, and that compliance was now 90% which was above the trust target.

Staff told us it could be difficult to manage workload between the doctors available, especially in the event of concurrent emergencies happening. Doctors covered multiple areas in the unit and that this resulted in patients experiencing delays during busy periods, particularly those awaiting ultrasound scans and ultrasound scan reviews.

### Records

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

Woman and birthing people's notes were comprehensive, and all staff could access them easily. The trust had been using an electronic notes system since June 2022. Staff felt confident and competent to use electronic records. However, staff and senior leaders told us there were developments required to the electronic system to allow for better auditing of records.

The service recognised there were issues with the quality of information being sent out through the electronic system within discharge letters. There was a lack information around the care given. The service told us they were working towards a trust-wide improvement programme to rectify these aspects of the electronic system.

As part of a trust-wide implementation, staff were able to ascertain when woman and birthing people transferred to a new team, for example, back to their GP or to community teams. There were no delays in staff accessing their records. We reviewed 10 electronic records and found records were clear and mostly complete. However, some areas were not completed in full, such as ‘fresh eyes’ reviews of electronic fetal monitoring in labour, risk assessments throughout pregnancy, and the completion of electronic fetal growth charts. Confidential information was protected and could not be accessed without a password; all computer screens were kept locked.

We saw that the electronic system was easy to navigate. The service ensured the allocation of named midwives or consultants to women and birthing people. Venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and fetal data during labour), World Health Organisation (WHO) theatre checklist, charts for growth and early warning scores were completed within the system.

# Maternity

Potential safeguarding issues were flagged electronically so all clinicians could recognise and act on safeguarding concerns.

All pregnant women and birthing people could access their maternity notes online. Women and birthing people had individualised care plans for pregnancy and labour, and there was antenatal screening and assessment of risk to promote safe treatment. Women we spoke to told us they liked using the online maternity notes.

### Medicines

**The service used systems and processes to safely prescribe and administer medicine. However, daily safety checks were sometimes missed, and there was out of date medicine.**

Staff mostly followed systems and processes to prescribe and administer medicines safely. However, we found expired medicines including antibiotics, anti-coagulant injections, and emergency medicines for haemorrhage. During February and May 2023, 1 daily check for controlled drugs was not completed. Medication was kept secure, neat, and tidy in medication cupboards.

Staff reviewed each woman's medicines regularly and provided advice to women, birthing people, and carers about their medicines. However, there was no formal process of checking stock or expired medication, and there were no daily pharmacy checks.

Clinical fridge temperatures were maintained between a minimum and maximum recommended temperature. However, not all fridge temperatures were checked daily to ensure required medication was stored at the correct temperature to maintain drug efficacy.

Pharmacy visited the unit weekly to review medication and to check stock. However, we found some staff were not aware of the weekly checks and were unsure the process of checking out of date stock.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Staff completed medicines competency testing and data submitted by the trust showed 92% compliance which met the trust target.

Newly qualified staff completed a medicines management test and competency assessment on the ward as part of their preceptorship. Once staff had completed both the theory and practical assessments, they were able to administer medication.

Staff who had been employed from a different trust were asked to provide evidence of medication assessment and training, otherwise they would complete the trust competency assessments.

Staff completed medicine records accurately and kept them up to date. Women and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had completed them.

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.

# Maternity

### Incidents

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

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

Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated national Strategic Executive Information System (STEIS) if a serious incident was declared.

Managers investigated incidents. Women, birthing people, and their families were involved in these investigations. There was a well-embedded assurance process for investigating, managing, and monitoring incidents which included external safety recommendations and shared learning. Managers analysed incidents for themes and trends in order to drive improvement and shared the learning with staff. However, we found that the service did not always harm-grade incidents appropriately according to NHS England advice which reduced the opportunity for learning and improvement.

Managers reviewed the Healthcare Safety Investigation Branch (HSIB) recommendations and any serious incidents on a regular basis so that they could identify potential immediate actions.

The trust had regular, quarterly meetings with HSIB to review the current methods of reporting and learning, and look at regional and national data. The trust sent a HSIB newsletter to all maternity staff to update on all incidents reported to HSIB and actions/ recommendations taken.

All reported incidents and near misses were monitored by the patient safety team. Learning from incident reviews was disseminated to staff through clinical governance newsletters, departmental meetings, clinical audit meeting, and individual staff feedback. Feedback was given to staff by educational supervisors, consultants, and matrons. The service told us where trends were identified further audits or reviews were undertaken as necessary.

Incident reporting on both sites was collected through data from the electronic recording system and completion of incident report forms through the electronic reporting system.

Perinatal mortality review meetings were attended by midwifery managers and clinical leads. The combined perinatal death rate for both trust sites were 3.95 which was below the national average.

At Frimley Park Hospital, there was 46 open obstetric incidents over 60 days old. The trust told us that 3 out of 46 related to serious incidents, and 3 out of 46 were PMRT cases awaiting external review prior to closure.

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

Matrons and specialist midwives disseminated quarterly messages amongst staff which included learning from incidents. Staff met to discuss the feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

# Maternity

## Is the service well-led?

Good

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

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. There was a clear triumvirate leadership structure in place consisting of a Chief of Service (Consultant Obstetrician and Gynaecologist), Director of Midwifery, and Associate Director of Womens and Childrens Services. The site Head of Midwifery reported directly to the Director of Midwifery.

The Head of Midwifery was supported by the consultant midwife, antenatal care and community matron, inpatient matron, intrapartum matron, and gynaecology matron.

There were three cross-site roles: the lead midwife for practice and development, antenatal and newborn screening lead, and clinical governance lead for maternity and gynaecology.

Leaders were visible and approachable in the service for woman and birthing people and staff. Leaders were respected and staff told us they found the matrons to listen, be supportive, approachable, and keen to drive improvement.

The service was supported by maternity safety champions and non-executive directors. The non-executive director (NED) was a maternity safety champion and aimed to provide objective and external challenge. Their remit was to understand the current outcomes of the service, review services, current maternity risks, and report to board.

The maternity safety board champions visited the maternity unit and liaised with outside representatives such as the maternity voices partnership group to review services and provide the board with a report of maternity services. The maternity safety champions consisted of executive and non-executive directors.

Leaders supported staff to develop their skills and take on more senior roles, there was also a number of specialist midwifery roles.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. 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 vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision for maternity services was detailed and was an integral part of the overall trust strategy. The impact of this was direct oversight from the executive team in order to better drive improvement.

# Maternity

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. There was an in-depth strategy in place across the Local Maternity and Neonatal System (LMNS) from September 2022 which had a focus on health inequality, and recognised gaps in trust Workforce Race Equality Standard (WRES) data and how to improve them. However, the trust worked alone in its LMNS and leaders told us they reached out to neighbouring regional and national teams to assist in benchmarking and collaborative working.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of people receiving care. The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear.**

Managers took into account results of the staff survey 2022 and had developed an action plan to improve on points made by staff, for example access to equipment, staff recruitment and retention, and meaningful appraisals. Procurement of equipment had been added to the risk register and staff were supported to raise incident reports when equipment was not available. There was a rise in positive responses in 85% of questions and staff reported being part of a team and proud of the care they were able to give to women and birthing people.

Managers investigated complaints and identified themes. In the 3 months preceding the inspection there were 9 complaints made to the service at Frimley Park Hospital and 7 of these remained open at the time of the inspection. Managers shared feedback from complaints with staff and learning was used to improve the service. There were effective systems in place for managing complaints and managers reviewed complaints for themes and trends.

Main themes identified within recent complaints were consent, communication, and care and treatment. During the factual accuracy process, the service told us all complaints had been closed within the required timeframe. The service said it reviewed complaints for themes over 6-12 month timeframes and had implemented several improvements in response, such as greater flexibility on partner visiting times, breastfeeding peer support, and continuous evaluation of the telephone advice line.

Results from the General Medical Council Survey (2022) showed maternity services at Frimley Park Hospital scores were in the top 25% of trusts in reporting systems and educational governance. No scores in the survey were below the national average, and scores had improved on the previous year in 16 out of 19 categories. The most significant improvements in the survey were in experience, and teaching categories.

The trust was participating and engaged in the Perinatal and Cultural Leadership Programme, NHS England, a scheme designed to encourage flat hierarchy, recognising the value of staff and clinical quality improvement. However, staff told us that there was a disconnect between midwifery senior leadership and obstetric staff. For example, problems may be identified as midwifery or obstetric-based separately, and there was not always a sufficient multi-disciplinary team-based approach. We saw evidence of a 72-hour review and action plan following a serious incident where the obstetric team were not mentioned or involved. This reduced the potential for shared learning and improvement across the service and affected staff morale. During the factual accuracy process, the service said this was a one-off incident and there remained a strong value on multi-disciplinary working.

# Maternity

Staff told us a lack of in-person meetings negatively impacted effectiveness and joined-up working between midwives and doctors, and that more could be done by leaders to encourage collaborative working between service-level staff and service leaders. During the factual accuracy process, the service told us specific face-to-face meetings had been reinstated and were increasing following COVID-19 measures, with the option of staff joining electronically to provide maximum opportunity to attend.

Staff told us 'hot debriefs' (debriefs with staff immediately following adverse events) were not embedded into daily practice and there was no team approach for their use. Staff told us increased demands on time could result in a lack of supervision for medical trainees and that staff suggestions for improvements were not always listened to or actioned by service leaders.

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

Staff could give examples of how they used women's feedback to improve daily practice.

### Governance

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

There was a team of maternity safety champions consisting of executive and non-executive directors. Maternity safety champions told us they visited wards every 2 months. We asked for documentation from the latest 3 safety champion ward visits however, this was not provided. During the factual accuracy process, the service submitted notes from 3 safety champion ward visits between March 2023 and August 2023. Notes were brief but detailed themes of conversations with staff including Entonox scavenging, supply chain concerns, and prescribing medications in a timely way. We did not see evidence of actions arising from the ward visits.

There was a cross-site obstetrics clinical governance meeting every 2 months which provided updates and discussion on issues including but not limited to risks, patient safety, practice development, national reports, and safeguarding.

Patient safety and quality meetings were held every month to discuss complaints, incidents, and safety recommendations.

The board of directors held cross-site meetings every 2 months to discuss trust wide issues and we saw meeting minutes that showed brief, high-level discussion of maternity risks took place when maternity services featured on the agenda in the annual business cycle.

A cross-site maternity patient safety report was presented to the trust quality committee every quarter which demonstrated oversight of statistics and open incidents. However, some information useful to assessing safety and performance was not included, for example audit results for fetal monitoring in labour, and recognition and possible reasoning for disproportionately higher rates of postpartum haemorrhage (PPH), obstetric anal sphincter injury (OASI), and medication errors at Frimley Park Hospital compared with Wexham Park Hospital. Rates of stillbirth across the trust (at both sites) were lower than the national rates. During the factual accuracy process, the service provided evidence to show many of these metrics were acknowledged and discussed at the cross-site labour ward forum.

Staff expressed concern about the set-up of the patient safety and quality meeting and its effectiveness. Staff told us there was a lack of multi-disciplinary involvement from start to finish when case reviews were done. Staff told us this had not translated into safety concerns but that this had a negative effect on culture and staff morale as staff did not always feel valued, and opportunities for shared learning and improvement were missed. Some senior staff did not have an in-depth knowledge of incident management techniques or a detailed overview of risks in the service.

Staff followed policies to plan and deliver care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies for updates. During inspection we found 3 policies were overdue updates: Sepsis, Care in Labour, and Deterioration of maternity patients and the use of MEOWS charts. These are high-risk guidelines and one had been awaiting an update since June 2022. Leaders were aware of the need for review and although progress was being tracked, the development and ratification of these guidelines and policies was slow and may impact on women and birthing people receiving safe care.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The service had no local live maternity dashboard to monitor service performance and identify risks, areas for improvement or areas of excellence. This was because the end-to-end IT system implemented in 2022 was not able to extract the data. This was a known risk and was monitored by leaders. Leaders were in discussions with the system provider and the risk management team to expedite the ability to extract reliable data.

Staff and senior leaders told us there were developments required to the electronic system to allow for better auditing of records and a clearer overview of risks. For example, the maternity dashboard could not provide the inspection team with an up-to-date, clear overview of key maternity performance indicators against national and local targets. At the time of inspections, information showed data up to December 2022 and therefore, we had no up-to-date information to ascertain whether the trust was assured they were meeting key performance criteria. During the factual accuracy process, the service supplied updated evidence of dashboard data and how it maintained oversight of performance during the implementation period of the IT system.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers audited trust performance against the Saving Babies' Lives Care Bundle v2 (SBLCBv2). The trust was unable to perform the recommended pathway of ultrasound scans however, compliance rates had improved in the 3 months before the inspection and the service said training for sonographers was in progress to ensure continued sustainability. Some metrics that the trust reported on quarterly were not provided when we asked.

Managers monitored Healthcare Safety Investigation Branch (HSIB) cases and routinely identified learning that was shared at trust board level. Between October 2022 and March 2023 there were 3 reports returned from HSIB. Out of 3 reports, 1 contained no safety recommendations and 2 contained safety recommendations around holistic reviews of women and birthing people, partogram completion in labour (a graph to monitor and visualise normal progress in labour), appropriate and safe escalation, and informed consent. All HSIB cases were investigated internally by the trust as well as independently by the HSIB. Serious incidents and HSIB cases went through a 16-step governance assurance process. This was to ensure there were no immediate actions needed to be taken, whilst the trust waited for the HSIB investigation to be completed.

Managers monitored safe levels of inhalational nitrous oxide (Entonox, or gas and air: for pain relief in labour) and there was an action plan to maintain safe levels on the maternity units on both hospital sites delivering maternity care as part of Frimley Health NHS Foundation Trust. There was not a current guideline for maternity services on safe levels of Entonox however, this was being drafted at the time of inspection.

The latest rapid quarterly report from the National Maternity and Perinatal Audit (August 2021 to July 2022) showed the service performed worse than the national average for the number of babies that were born small for gestational age. This could be due to the case mix of women and birthing people. During the factual accuracy process, the service said its response to this was the introduction of electronic growth charts which reduced the impact of human error when measurements were plotted.

The Maternity Local Risk Assurance Framework showed the current risks within the service as well as the current level of risk rating. From May 2023, the framework showed the maternity service had 13 risks in total rated high, moderate, and low. High on the risk assurance framework was midwifery staffing. Risks were discussed and documented in the quarterly safety report to the quality committee, and the board had an overview of all maternity service risks and the severity of each.

There was a training needs analysis to support the achievement of training and improvement goals. This included workforce planning, future service developments, and recognised current key risks within the service in order to focus improvement.

Leaders had an action plan in place to improve staff numbers through retention and recruitment using various initiatives including return to practice for midwives who have left the profession, international recruits, and staff reward and wellbeing schemes. This demonstrated that the trust was responding to the risk of low staffing, and during the factual accuracy process the service provided data to show progress against the action plan had been successful. During the inspection managers told us that some international and domestic recruiting had been successful and data showed as of February 2023, 45 midwives had been recruited cross-site, but there remained vacancies. Managers told us the close proximity to London and the difference in salary had impacted their ability to recruit and retain in the trust. The service had been well supported at an executive level in bolstering midwife numbers with uplifts in funding, staff templates, recruitment and retention drives, and partnerships with local universities to offer additional places for students and training in midwifery for nurses and support workers through apprenticeship schemes.

The trust collected data for the NHS Workforce Race Equality Standard (WRES). Overall, for midwives (of all ethnicities pooled), the organisation performed at a similar level to the national average however, the level of belief that the organisation provides equal opportunities for career progression or promotion was lower amongst staff from ethnic minority groups than amongst White staff. Additionally, the level of discrimination from other staff was numerically worse for staff from ethnic minority groups than for White staff, and this trend may have achieved statistical significance had the number of respondents from ethnic minority groups been higher.

The trust was informed in May 2023 by NHS Resolution that all 10 Clinical Negligence Scheme for Trusts (CNST) had been met. CNST is a payment made to NHS Resolution as a premium for the insurance product covering NHS organisations for claims against clinical negligence.

The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Mortality Reviews Summary Report (PMRT) tool and produced a quarterly report. The trust provided data to show this information had

been reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). MBRRACE-UK is a national audit programme to collect information on late fetal losses, stillbirths, neonatal and maternal deaths. The service had completed a 9-year review (2014-2023) of stillbirths and neonatal deaths which confirmed the rate was 5%-15% lower than the national average.

### Information Management

**The service collected data and analysed it. It was sometimes difficult for staff to 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 data and analysed it however, the introduction of a new IT system at the trust in June 2022 had resulted in difficulty collecting, auditing, and reporting data in a timely and accurate way. The trust had recognised this as an issue, and it was being monitored via the corporate (trust-wide) risk register. During the factual accuracy process, the service submitted evidence to show how they maintained oversight of the service using 'snapshot' audits and data-tracking systems which showed all necessary key performance indicators. The service monitored the CNST scorecard monthly, and said updates to enable full extraction of data from the IT system were due imminently in 2023.

Data or notifications were submitted to external organisations as required however, it was difficult for the trust to be assured on the accuracy of the data whilst the system was becoming embedded, changes to software were made, and staff learnt to use it and record on it effectively. The service failed data quality tests in 4 out of 12 (25%) sections of the clinical quality improvement metrics (national data to identify areas of good practice or for improvement), and the impact of this was a lack of assurance around accurate data being collected and presented. During the factual accuracy process the service said the smaller amount of data being analysed resulted in the national data quality tests not being met.

Staff told us that the IT system was easy to use and contained the information they needed however, in some areas it had increased time required to complete administrative tasks. Staff told us that leaders did not always acknowledge extra time pressures, and that the ability to review documents electronically off-site was convenient however, created a lack of time for doctors to earmark for other tasks or rest.

Staff could find the data they needed in order to make decisions about women and birthing people's care.

The information systems were integrated and secure, and the system was used throughout all trust departments which ensured access to consistent documentation and contemporaneous care records.

### Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP chairs told us there was good relationships with the trust and women's and birthing people's voices were seen as important. The MVP were involved in meetings such as the Local Maternity and Neonatal System (LMNS) and clinical governance meetings. The service had involved the MVP in several quality improvement projects including birth choices, birth reflections, maternal mental health provision, 'birth boxes' (a birth-room kit including pictures,

positive mindset messages, fairy lights, and non-pharmacological pain-relieving equipment), breastfeeding peer support, and Down Syndrome support packs. The MVP chairs had support and funding from the service to appoint an engagement lead, to continue seeking the views of local service-users from hard-to-reach groups, and to continue work on cultural sensitivity and health inequalities.

Results from the CQC Maternity Survey (2022) showed the service performed as expected in 45 questions and better than expected for 6 questions. The service performed best in provision of care and information antenatally. There were some statistically significant decreases in respondents' satisfaction between 2021 and 2022 in delayed discharges and access to staff for help and information. When 173 respondents of the survey had the opportunity to tell us what was most important about their experience, there were consistent themes of feeling unsupported, negative interactions with staff, and being spoken to unkindly. Women and birthing people told us they were aware of the impact of short staffing within the service as procedures and sometimes emergencies were delayed. Women and birthing people told us they had requested discharge from hospital due to negative experiences with staff even when they were in pain or did not feel well enough. However, there were positive comments regarding the general quality of care, especially during labour and birth, and many respondents felt cared for and were treated kindly by staff. During the inspection, women and birthing people we spoke to were positive about the environment, staff, and the care they received.

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

The service shared information with staff through listening events, posters, maternity patient safety and quality update newsletter, and maternity voices partnership minutes.

'You said, we did,' posters were on display around the unit. Posters were produced following listening events with the maternity senior leaders. Information received from the listening event taking place in March 2023 identified staff had raised poor experiences for new starters. Senior leaders followed this up by putting actions to make collecting ID badges easier, improving the communication with human resources for new starters as well as providing individual training for the electronic records system.

The maternity service had an equality action plan and steering group to create a number of projects to support the local community. Projects included health promotion and health education to improve genetic testing information, staff listening groups, and community education sessions.

Leaders understood the needs of the local population.

Leaders held listening events with staff to address any issues or concerns. Some examples of improvements made as a result of listening events include improvements to the escalation process when there was a lack of medical staff, and the introduction of a year-long retention and recruitment project within maternity services.

### Learning, continuous improvement and innovation

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

The service had won a recognition award for its work in babies being born in the correct place, which aimed to reduce the incidence of poor outcomes. It did this by ensuring that women and birthing people were transferred to tertiary units prior to giving birth if premature labour was indicated.

# Maternity

The service was committed to improving services by learning when things went well or not so well. There was evidence of quality improvement projects. During the factual accuracy process, the service provided data about implementation of the OASI 2 care bundle to prevent and treat severe perineal tears planned to commence in June 2023.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. There was a research newsletter to inform staff about ongoing and new research projects, and the trust worked with the National Institute of Health Research.

The trust worked within LMNS networks to devise and implement a new service for perinatal pelvic health, utilising specialist physiotherapists to take referrals. The service was assisting other trusts to implement the care model and disseminate learning.

Feedback was received from women and birthing people that the information and communication given by the maternity service following a diagnosis of Down Syndrome could be improved. The service worked with women and the maternity voices partnership team to produce postnatal information packs for families. The packs contained peer support group information, practical advice and further training.

The trust developed learning from incidents through quality improvement. During our inspection, staff told us and showed us quality improvement projects had taken place. These were an induction of labour working group to improve flow, and support women and birthing people to make informed decisions around induction. The service had also developed a designated maternity telephone triage and advice line used cross-site, with a shared referral pathway to ensure women and birthing people were given consistent advice.

Learning and continuous improvement was shared with staff through the monthly clinical governance newsletters. The newsletters showed themes from patient safety incidences, areas of good practice, updates on current guidance as well as current working groups and initiatives taking place.

## Outstanding practice

We found the following outstanding practice:

- The service was an early adopter of and was leading work to devise and implement a new perinatal pelvic health service utilising specialist physiotherapists to take referrals. The service advised other trusts and LMNS networks on successful implementation.
- The maternity service had won a recognition award for work in ensuring women and birthing people in premature labour were recognised and transferred to tertiary units. The aim of the work was to reduce the incidence of poor outcomes.
- The service was an early implementer of a maternity telephone triage line and assists other trusts with successful implementation.

## 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.

# Maternity

### Frimley Park Hospital maternity services

### Action the trust MUST take to improve:

- The service must ensure all staff have completed mandatory training. (Reg 12)
- The service must ensure that infection prevention and control measures are carried out effectively and the clinical environment and equipment is clean and fit for use. (Reg 12)
- The service must ensure that medicines are checked and stored safely. (Reg 12)

### Action the trust SHOULD take to improve:

- The service should ensure correct and effective use of MEOWS and NEWTT charts to accurately identify deteriorating patients.
- The service should ensure safety huddles and handovers are conducted in a standardised way, in a suitable environment free from interruptions.
- The service should ensure records are completed in full, and that effective audits take place using reliable data.
- The service should continue to ensure there is an accurate overview of risks faced, including how assurance is gained in the absence of a live maternity dashboard or ability to extract all suitable data from IT systems.
- The service should ensure all staff have annual appraisals.
- The service should ensure incidents are graded appropriately.
- The service should ensure policies and guidelines are up-to-date, and that there are effective processes in place to manage them.
- The service should consider the addition of a supernumerary co-ordinator to oversee staff and acuity across the whole maternity unit effectively.
- The service should continue work on completing guidelines for maintaining safe levels of inhalational nitrous oxide on the maternity unit.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, 4 other CQC inspectors, an obstetric specialist advisor and 2 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.