Frimley Health NHS Foundation Trust

Wexham Park Hospital

Inspection report

Wexham Street
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Ratings

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

Our findings

Overall summary of services at Wexham Park Hospital

Good 

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

We inspected the maternity service at Wexham 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 unannounced 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 previous rating of good remains.

We also inspected 1 other Maternity service run by Frimley Health NHS Foundation Trust. Our report is here:

Frimley Park Hospital – https://www.cqc.org.uk/location/RDU01

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:

- 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. They managed medicines well. 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. 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:

- Mandatory and safeguarding training figures showed not all staff were up to date with their training including key skills, such as, multidisciplinary obstetric emergency skills and drills and safeguarding training. Babies' observation charts were not always 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, and 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 staff. However, not all staff had met the trust target for training.

The trust had mostly returned to face-to-face training, where possible, for all staff. Training compliance for the trust was 90%.

Training included multidisciplinary obstetric emergency skills and drills, equality and diversity, information governance, adult and children's basic life support and fetal monitoring.

Maternity

From January 2023 to May 2023, staff were not trust compliant in all mandatory training areas. Maternity staff were 88% compliant in equality and diversity, 88% compliant in maternity obstetric emergency skills and drills, gap and grow training 84% and 85% compliant in adult level 2 resuscitation. Medical staff were 78% compliant in gap and grow training and 88% compliant in blood transfusion training,

Newborn life support was delivered during the emergency skills training day. Both neonatal staff and paediatricians took part in the training and participated in the multidisciplinary learning.

The training day included cord prolapse, vaginal breech birth, shoulder dystocia, perinatal pelvic health and impacted fetal head. Maternity and medical staff were not trust compliant for maternity obstetric emergency skills and drills training, with 88% of maternity staff and 84% of medical staff had completed the training.

Fetal monitoring was a multi professional training day and included both antenatal and intrapartum monitoring. Local and national maternal outcomes played a focus on these training days using scenarios based on local incidents or learning from case studies. Midwives were 95.4% compliant. However medical staff had not met the trust target and were 87.8% compliant. The service told us the next training date for fetal monitoring was in July 2023, and the consultants who had not attended the training were booked to complete.

There was a 3-year training plan in place as part of the core competency framework in maternity. The framework aimed to develop competency-based assessments to provide consistency in training to address areas within maternity of significant harm.

The 6 core modules of the competency framework were, Saving Babies Lives Care Bundle, Fetal surveillance in labour, Maternity emergencies and multi-professional training, Personalised care, Care during labour and the immediate postnatal period and Neonatal life support.

Emergency pool evacuation training was added to the mandatory training schedule from April 2023. The training included an in-situ simulation, viewing a filmed simulation, or attending PROMPT training where maternal care in the pool was taught. The training had been in place for 1 month and data received from the trust showed 35.6% of midwives and 17.3% of medical staff had completed the training in May 2023. The trust had set out to have a 100% compliance rate for all midwives and medical staff by April 2024.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. Perinatal mental health training was included in the core competencies framework and maternity staff were 97.69% compliant.

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 lead for maternity practice development worked cross site between the two locations. Staff and students spoke highly of the team and felt well supported.

During the factual accuracy process, the trust said it had set mandatory training compliance target rates to 85%.

Maternity

Safeguarding

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Staff had mostly received training, and could describe how to recognise and report abuse.

Nursing and midwifery staff mostly received training specific for their role on how to recognise and report abuse. At the time of the inspection training records showed that not all staff had completed both safeguarding adults and safeguarding children training at the level required for their role, as set out in the trust's policy and in the intercollegiate guidelines.

Medical staff did not meet the trust target for both level 3 children's safeguarding and level 3 adults safeguarding. With 83.3% compliance in Level 3 safeguarding children's training and 88.3% compliance in Level 3 safeguarding adults.

Midwives were 99% compliant in Level 3 safeguarding children. However, did not meet the trust compliance in level 3 adult safeguarding training with 86% compliance.

Safeguarding training was provided inhouse 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.

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.

Domestic abuse was a mandatory field on the electronic records system, which meant staff could not move on until they had completed the question. Where safeguarding concerns were identified women and birthing people had birth plans in place which were produced alongside the safeguarding team. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the baby abduction policy and 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 baby abduction drills and reported to the inspection team that these were well run, with staff clear on the process to follow.

Cleanliness, infection control and hygiene

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

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Maternity

Maternity service areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. During our inspection we saw cleaners, cleaning all areas throughout the day. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Staff cleaned equipment after contact with women and birthing people. However, equipment was not labelled to show when it was last cleaned. Staff told us 'I am clean' stickers should be used to identify when equipment was cleaned. During the inspection we saw I am clean stickers were used on 3 pieces of equipment in the postnatal area only. Therefore, staff could not always be assured equipment was clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service.

Data provided by the trust showed both medical and midwifery staff were trust compliant in infection prevention and control (IPC) training.

The service completed IPC environmental audits. Audits were shown as a RAG (red, amber, and green) rating and looked at the general environment, environment of specific facilities and clinical practices. Each audit had an action plan attached to identify the area of concern, the action taken, timescale for completion and the person identified to complete the action. There was also an area to add comments around the actions. Maternity areas were 98% compliant in the environmental audits. During our inspection all maternity areas looked clean and were uncluttered.

Hand hygiene audits were not always provided for each area of the maternity service. The trust compliance for hand hygiene audits was 100% and staff were not always compliant. Data showed the maternity assessment centre had provided no hand hygiene data for February or March 2023. However, scored 100% for cleaning audits in April 2023 and May 2023.

Labour ward provided no hand hygiene audits for February 2023, we saw 80% compliance in March, no data for April and 97% compliance for May 2023.

Juniper midwifery led birth centre had 99% compliance in February 2023, no data for March 2023, 97% compliance in April 2023 and no data in May 2023.

Following the non-compliance in hand hygiene the service put in interventions to make sure staff were hand hygiene compliant. These were ensuring alcohol gel was in place around all areas, the effective and appropriate use of PPE, reminding staff not to have false or long nails, the importance of bare below the elbows and to observe handwashing techniques.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was in a purpose-built part of the hospital with a separate entrance into maternity. There was a clear flow from the maternity assessment unit which included maternity triage and antenatal clinics, through to antenatal and labour ward.

Maternity

The Juniper midwifery-led birthing unit was located on the second floor, next to the postnatal ward. All areas of the maternity unit were spacious and visibly clean with plenty of space in between beds on both the antenatal and postnatal wards.

Inductions of labour took place on the antenatal ward and there was a separate transitional care area for babies within the postnatal ward.

Staff mostly carried out daily safety checks of specialist equipment. We found there were 4 daily checks missing over the last month for the neonatal arrest resuscitation trolley, and 2 checks had not been completed on a resuscitaire in the labour ward. However, records showed in all other maternity areas the adult resuscitation equipment and baby resuscitaires were checked daily.

All equipment and store cupboards were visibly clean, tidy, and uncluttered. A fridge specifically for infant milk storage was kept in a locked room which stored medicines and dressings. The name, hospital number, date and time expressed were written clearly on all labels. The milk fridge was checked daily to ensure it was always locked, maintained at the correct temperature for safe storage.

There was a dedicated bereavement suite called the Willow suite situated within labour ward on the main corridor opposite the handover room. During the inspection we saw medical and maternity staff outside the room discussing care of women, birthing people and babies. The bereavement room was being used during our inspection and there was a green butterfly on the door to show this. Staff told us the room next to the bereavement room was not soundproofed and this meant people in the bereavement room could hear activity in the room next door.

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.

The service had enough suitable equipment to help them to safely care for women, birthing people and babies. There were 2 rooms with birthing pools which were spacious. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water. The birth centre had pool evacuation nets available and observation monitoring equipment.

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.
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Staff quickly acted upon women and birthing people at risk of deterioration. Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately.

Maternity

The maternity risk register was reviewed monthly at the maternity patient safety and quality group and was reported in the Obstetrics and Gynaecology departmental monthly meeting and submitted to corporate governance. Between January 2023 to March 2023 there were 14 risks recorded on the maternity risk register.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman and birthing person. We reviewed MEOWS records during the inspection and found staff had completed them fully and had escalated concerns to senior staff. However, the service told us between January 2023 to March 2023, staff raised concerns with the electronic notes recording of MEOWS. Staff found observations were not able to be uploaded correctly on the recording system and the system did not automatically calculate potential concerns in observations. Following these concerns, the service acted to ensure further development of the observations chart on the electronic system, and for staff to record all key observations. For example, to record if the woman looks unwell.

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 that 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.

Newborn early trigger and track was placed on the maternity risk register alongside the modified early obstetric warning score.

Staff shared key information to keep women safe when handing over their care to others. There was a multidisciplinary safety huddle including, anaesthetic team, consultants, medical staff, and labour ward coordinator which took place daily on the delivery suite. There was no formal handover sheet used during this meeting and we found there were several interruptions from staff.

The service had a twice daily ward round on the delivery suite as per national guidance. There was comprehensive consultant presence on-site and an obstetric lead was available in the maternity assessment centre (MAC) who could review women who flagged as at risk. Staff in the MAC knew how to escalate and were aware of key risks.

Shift changes and handovers in other maternity areas included all necessary key information to keep women, birthing people and babies safe. Each area of the maternity unit had a team handover twice a day to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, and recommendation (SBAR) for each patient.

The service set a target of 100% for 1 to 1 care for women in labour. Data showed from January 2023 to May 2023 the labour ward on average was 98% compliant and the birth centre was 100% compliant.

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist which included a sign in, time out, and sign out checks. Patients had a copy of the 'Five Steps to Safer Surgery' WHO checklist in their notes. The service was 100% compliant with the WHO checklist for January and February 2023 and 99% compliant in March 2023.

The service did not have a live maternity dashboard. The service shared that they were currently producing a programme on the electronic record database to be able to present live clinical dashboards and the maternity dashboard was due to go live in June 2023. The service reported through the national maternity database. The national database showed data up to April 2023.

Maternity

Maternal readmissions at the hospital were high. On the day of inspection 2 women were re-admitted following discharge after caesarean sections.

Maternal readmissions were a key performance indicator (KPI) and on average the service had between 10 and 11 mother and baby readmissions per month; this meant the readmission to birth rate for the service was around 3%. Data showed, 38 maternal readmissions from March 2023 to May 2023, with 15 of the readmissions being due to infection. The data showed a higher-than-average maternal readmission for the service and following the inspection a letter of intent was issued to the trust.

Following the letter of intent, the service told us there had been a notes review of all maternal re-admissions. There was no identified theme for maternal readmission, and women and birthing people had not been unwell at discharge. The service provided assurances that all readmissions were reported in the quarterly governance reports and maternal and baby readmissions would now be reported on and reviewed separately.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service introduced a standardised evidence-based tool in the maternity assessment centre to identify women and birthing people at risk of deterioration using a red, amber, and green RAG rated system on the electronic notes system. The maternity assessment centre (MAC) was supported by the standardised national tools and were provided with feedback from the regional midwife for the system. Feedback included what was going well and suggestions for improvement.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The information was collated through the introduction of a digital day book which monitored compliance.

Patients could attend the maternity assessment centre through a pre booked appointment or self-referral following a telephone triage with an experienced midwife. Midwives documented the time women and birthing people arrived at the unit and the time they were seen. All women and birthing people attending with reduced fetal movements were seen by a clinician within 15 minutes of their arrival onto the unit.

Staff in the maternity assessment centre (MAC) told us there had been a high incidence of women presenting late in labour and giving birth in the unit. There was a room set up within the MAC which was designated for emergencies and there were birth packs and a resuscitaire in place.

There was no specific guidance in place for women delivering in the MAC. Senior leaders told us midwives had been following the care of women in labour guideline for delivery of babies. However, this policy did not have guidance for midwives managing women delivering in the MAC.

The trust told us all births taking place outside of planned place of birth are reported under the trust incident reporting system.

From May 2022 to May 2023, there were 7 births which took place in the maternity assessment centre. Information showed 6 of the women and birthing people presented in advanced labour and were unable to be transferred to delivery suite due to birth being imminent. Staffing acuity in the delivery suite and birthing centre was a factor in 1 birth which took place within MAC, and it was not appropriate to transfer the woman or birthing person either cross site or to a neighbouring trust due to the advance stages of labour.

Maternity

Following the inspection, the service said assurance of the process for women and birthing people presenting in advanced labour and delivering their baby in MAC would be incorporated into operational guidelines for the maternity assessment centre and for any delivery in the MAC.

All cases of babies born at 27 weeks or under in maternity units were reported and reviewed. From January 2023 to March 2023 the service reported there were no incidences reported where a baby was born below 27 weeks.

Staff used an evidence-based, standardised risk assessment tool for women and birthing people. Staff used the 'Saving Babies' Lives Version 2 (2019), a nationally recognised care bundle to assess women during pregnancy. Saving Babies' Lives is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths by bringing together areas identified as best practice, these included reducing smoking in pregnancy, raising awareness of reduced fetal movement, and effective fetal monitoring during labour.

The service had over 80% compliance between January 2023 to February 2023 for carbon monoxide (CO) screening cross-site at booking. CO screening offered at 36 weeks showed compliance was less than 80%, which was below the national target. The service was adding information at booking to identify further CO data. For example, referral to smoking cessation and identification of the smoking status for everyone living within the home environment.

There was 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support woman and birthing people with mental health concerns. The service had clear processes for staff to follow which included the contact details of the onsite and out of hours psychiatric liaison teams. The service had a specialist perinatal mental health link nurse who attended weekly antenatal clinic.

The service had an induction of labour (IOL) action plan in place to improve the waiting times of women following artificial rupture of membranes. Data provided showed in February 2022 the longest waiting time was 72 hours, March 2022 the waiting time was 78 hours and in April 2022 it was 72 hours.

An IOL working group was set up in January 2023 with the aim to assess and plan for IOL provisions, look at data and waiting times to find solutions to long waits and to audit and investigate themes.

The labour ward had an IOL workload board in place for staff to have oversight of current workload. An electronic day book was in place to capture IOL wait times and the group were contacting local networks and maternity services to identify how IOL's were managed within their area. They were also creating information videos to provide women and birthing people with information on IOL's.

Midwifery Staffing

The service had enough maternity staff 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 including the use of bank and agency staff. All bank and agency staff had 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.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance.

Maternity

The service undertook a staffing review in 2020, with a phased implementation to increase midwifery staff. From April 2021, the service had full funding for midwifery staffing. However, as of March 2023 there had been an increase in staffing vacancies cross site to 48 whole time equivalent (WTE) with Wexham Park Hospital having a vacancy rate of 29.13 WTE. Maternity leave across the site was 12.35 WTE. This meant Wexham Park Hospital achieved the recommended staffing levels by using bank and agency staff.

Midwifery staffing was on the maternity risk register. From January 2023 to March 2023, the maternity unit was shown to be safely staffed and there were no unit closures.

The service had a maternity department communication and escalation policy in place and was available to staff on the intranet. The policy highlighted strategy and thresholds for staffing levels for the maternity service to manage short- and long-term staffing shortages.

Staff vacancies and sickness rates were reviewed at monthly matrons' meetings and at the obstetrics and gynaecology directorate board meeting.

To support the trust's recruitment concerns the service took part in a support programme offered by NHS England for recruitment and retention of midwives. Monthly reviews of the midwifery establishments were completed by the Heads of Midwifery, and staffing levels matched the planned numbers during our inspection.

Recruiting midwives and staff to the local area was difficult due to the high cost of living. Senior midwives told us there was a high level of bank and agency staff used within the service to make sure that daily staffing establishment was safe. Staff told us the same bank and agency midwives were used and they were well trained and had undertaken full inductions.

All agency staff were required to have a 'boarding' card completed by the midwife in charge of the shift. The card was to evidence the agency staff had an orientation to the ward. It meant ward managers could check bank staff identification and the staff member had access to trust guidance and the electronic record system.

From April 2022 the service had introduced a lead midwife for international recruitment. Their role was to support international midwives with relocation to the local area and to provide emotional support.

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.

There were several specialist midwife roles within the service. Staff told us the specialist midwives were visible across the unit and were supportive and responsive.

There was a variety of specialist midwives employed within the services. These included an antenatal screening midwife, diabetes specialist midwife, infant feeding midwife, lead midwife for clinical learning, patient safety lead midwife, perinatal mental health midwife, practice development midwife, pregnancy loss midwife, safeguarding midwife, IT lead midwife and the quality, audit and patient experience midwife.

Wexham Park Hospital was also in the process of recruiting a close relative marriage midwife. The role was part-time, and the aim was for the midwife to work closely with the local Pakistani community to create a greater level of awareness for genetic testing.

Maternity

Between January 2022 to March 2022 the Juniper birth centre had been frequently used to care for postnatal women testing positive for COVID-19, and between July 2022 and September 2022 the birth centre was closed due to staff shortages with women and birthing people being diverted to the labour ward. This meant there was a lack of midwifery-led care for women and birthing people. Staff told us they found this disappointing for well women and birthing people who chose to have midwifery led care. Staff said this had led to some staff vacancies within the midwifery led birthing centre due to midwives preferring to work in midwifery-led care.

The practice development lead told us the service had expanded the number of training places for student midwives across site to support future recruitment.

Compliance rates for staff appraisals was low. Out of 208 midwifery staff, 68 staff had not had an appraisal. This meant the service was 67.31% compliant. However, the appraisals for midwives supervising students were 100% compliant.

Medical staffing

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

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Following a review of training data in 2021 by the Royal College of Obstetrics and Gynaecology (RCOG), the service was found to be within the top 10 performing units for professional development and obstetrics training.

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 Trust had 41.2 WTE consultants (Obstetrician and Gynaecologists) which included the Chief of Service and Specialist Fetal Medicine Consultant. Wexham Park Hospital had 20 whole time equivalent consultants who were part of the staffing rota. 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 cover had cover built in to cover holiday and other consultant 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 hand over. The consultant then become the non-resident consultant who covered the obstetrics and gynaecology unit from home until 8am the next day.

Saturday and Sundays the resident labour ward consultant with no other responsibilities worked from 8am to 8.30pm.

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.

Compliance rates for staff appraisals was low. Out of 30 medical staff, 12 staff had not had an appraisal. This meant medical staff were 60% compliant.

Maternity

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 and a clearer overview of risks.

The service recognised that through the electronic system there were issues with the quality of information being sent out 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 improve 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 complete. 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.

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, there was an antenatal screening and assessment of risk to promote safe treatment. Women we spoke to told us they liked using the online maternity notes.

The electronic notes system was still under improvement to meet the needs of the maternity service and senior leaders told us this included improvement to the services audit process.

The maternity assessment centre (MAC) used an electronic obstetric triage system. The triage system was designed specifically to be used with maternity triages and maternity assessment centres. Every woman and birthing person entering the MAC had an immediate assessment as part of the triage system to determine the urgency to which the woman or birthing person needed to be seen.

Medicines

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

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 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.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medication was kept secure, neat, and tidy in medication cupboards. However, we found expired medicines in labour ward and medicine in the emergency pre-eclampsia box was out of date.

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 stay. 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.

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. We found out of date medication in the labour ward fridge and a missing temperature check.

There was ultrasound gel found in triage and on the delivery suite which should not have been available due to a medicine safety alert relating to the gel. This was escalated to staff during the inspection and was removed during the inspection.

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.

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 reviewed the Healthcare Safety Investigation Branch (HSIB) and any serious incidents. incidents on a regular basis so that they could identify potential immediate actions. The trust had a process for managing and reviewing incidents and near misses.

The trust had 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.

Maternity

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 collated 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.

Wexham Park Hospital had 69 open obstetric incidents with 2 over 60 days old. The trust told us 1 related to a serious incident and the other was related to a HSIB case. Incidents classed as severe harm are any unexpected or unintended incidents that appear to have resulted in permanent harm to one or more persons.

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 of the involvement of women, birthing people and their families in investigations, and monitoring of 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.

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 further evidence during the factual accuracy process to show this information was reported to MBRRACE.

MBRRACE is a national audit programme to collect information on late fetal losses, stillbirths, neonatal and maternal deaths.

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 Women's and Childrens Services. The site Head of Midwifery reported directly to the Director of Midwifery.

Maternity

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 which were 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 women, 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. Maternity safety champions told us they visited wards every 2 months. We asked for documentation from the latest 3 safety champion ward visits however, these were not provided.

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 maternity service's vision was in collaboration with the Local Maternity and Neonatal System (LMNS) and Maternity Voices Partnership (MVP). The service had developed workstreams and strategies to help support women to be healthy before pregnancy and to have a safe birth. These were to improve digital workstreams, developing a long-term plan within postnatal care, continuity of care teams, addressing health inequalities and the local perinatal 5 year plan.

The service worked with the MVP to engage women and birthing people with protected characteristics within focus groups to identify the difficulties they experienced whilst on the postnatal ward. Actions following on from the focus groups included developing a continuity of carer for vulnerable women, workshops and resources on perinatal mental health and where to finder further mental health support.

Leaders informed us of the challenges in place due to further development needed on the electronic recording system to allow for clearer oversight on auditing processes.

The service was continuing work to improve recruitment and retention and had introduced specialist midwives to support this agenda.

The trust published an equity plan in September 2022, to raise workforce inequalities and highlight the gaps in outcomes for women and birthing people attending the maternity service from deprived areas and from minority ethnic backgrounds. Leaders spoke around improving the outcomes for women and birthing people.

Maternity

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.

Culture

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

Staff were positive about the department and its leadership team and was able to speak to leaders about difficult issues and when things went wrong.

Following the staff survey in 2022, the service put together an action plan to respond to issues raised within the survey and to identify actions taken. Staff wanted more feedback on their work and to be recognised for the work they do. Some of the actions taken to support this were to make it clear to staff who their immediate manager was, all inpatient and intrapartum band 7's to email staff that they line manage regarding roles and escalation, work to create a check out system at the end of each shift for inpatient areas, antenatal care, diabetic team, and community hubs messages to be shared in team meetings, a maternity blog, a safety hub, and matrons to attend ward meetings with a focus on celebrating success. The structure of unit meetings were to include something positive that staff have achieved within that area.

The Director of Midwifery produced a monthly maternity blog to share learning from incidents, maternity updates, maternity opportunities, and staff found the blog useful and informative.

Staff reported in the survey they were proud that the service listened and worked co-productively with the maternity voices partnership to listen to feedback from women and birthing people about their experiences.

Staff told us they felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

The Trust participated in the Perinatal and Cultural Leadership Programme as part of NHS England, 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.

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

The trust had in place a midwifery workforce plan which showed the potential outflow of midwifery staff for example, midwives due to retire, as well as the potential inflow of midwifery staff such as graduate midwives and international recruitment. This information was also highlighted within the trust improvement plan.

Maternity

The service had a clear plan of objectives on how to recruit and retain staff with a focus of engagement and reviewing staff wellbeing and pastoral support.

The service clearly displayed information about how to raise a concern in woman and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. From February 2023 to April 2023 there were 12 complaints made to the service at Wexham Park Hospital. 11 out of the 12 complaints remained open at the time of the inspection. Main themes identified within the complaints were consent, communication, and care and treatment.

The trust provided further information during the factual accuracy process about the number of complaints as of May 2023; common themes and improvements the service had put in place. The service told us there were 21 complaints, with 18 open. All complaints were closed within the agreed timeframe. One of the common complaint themes was a lack of breast-feeding support on postnatal wards. Once this was identified the service introduced peer support volunteers to support mothers to breast feed on the wards.

The trust had joined a culture and leadership scheme designed to encourage staff, recognising the value of staff and clinical quality improvement.

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.

The triumvirate consisted of the Director of Midwifery, Associate Director for Women and Children's Services, and the Chief of Service. The triumvirate met on a weekly basis. However, the divisional triumvirate meetings were not minuted.

The trust had maternity safety champions working across service boundaries to develop partnerships and develop a clear structure for sharing risks from the ward through to board. For example, the board level safety champions provided information to the board regarding the Saving Babies Lives, the Maternity Safety Incentive Scheme, serious incidents, and Healthcare Safety Investigation Branch (HSIB) cases. They supported the implementation of learning from national and local initiatives and provided feedback to the board on key priorities for maternal and neonatal safety.

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 showed themes of conversations with staff including the increase in women and birthing people being diagnosed with gestational diabetes, drug stock replenishment, and equipment. We did not see evidence of actions arising from the ward visits.

Clinical governance meetings were cross site and took place every 2 months. The meetings 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. There were effective systems in place for managing complaints and managers reviewed complaints for themes and trends.

The board of directors held meetings in public every 2 months to discuss trust wide issues and we saw meeting minutes that showed high level discussions of maternity risks, when maternity services were featured on the agenda as part of the annual cycle of business.

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 stillbirth and postnatal readmissions at Wexham Park Hospital compared with Frimley Park Hospital. Rates of stillbirth across the trust (at both sites) were lower than the national rates and this was reported within the quality committee meeting. 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 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 however, these were not always effective. 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 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 that was 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 the key maternity performances against national and local targets. At the time of inspection, 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.

The trust shared key quality issues, risks and concerns related to or affecting maternity care and services with the local maternity and neonatal systems (LMNS) reporting template. Information was reported quarterly. Information shared with the LMNS Electronic Patient Record (EPIC) launch highlighted continuous issues with the electronic reporting system with monitoring data quality, barriers to share information and integrating audits and dashboards with national systems.

Maternity

Emerging risks identified within the maternity service were a national safety alert for Entonox use, future junior doctor strikes which have a direct impact on the maternity service, and the number of pregnant women with complex mental health and safeguarding concerns increasing.

All Healthcare Safety Investigation Branch (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.

The trust had a clear incident reporting and investigation pathway which detailed the process followed to review different types of incidents and reporting. For example, all late fetal loss, antenatal, and intrapartum stillbirths followed the route to report through the perinatal mortality review tool and actions taken were determined through the process flow chart.

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 trust reported pregnant women were not receiving the best mental health care when admitted on to obstetric units. The team described an incident where there had been a lack of risk assessment and process for women and birthing people in mental health crisis being admitted onto the ward. The maternity service was in the process of developing a standard operating procedure to work closely with mental health teams providing care to women and birthing people that were admitted onto the ward.

Both hospital locations worked together to manage activity and not to close the maternity units, however, they have diverted women cross-site. From January 2023, Wexham Park Hospital diverted 7 women to Frimley Park Hospital as part of the trust's escalation policy.

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 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.

Leaders had an action plan in place to improve staff numbers through retention and recruitment improvement plan which included 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. During the inspection managers told us that international and domestic recruitment had been successful.

Data showed as of February 2023, 45 midwives had been recruited cross-site, but there were still vacancies. Managers told us the 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.

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 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 patient care. The trust had an active MVP and the group had 2 co-chairs who met monthly to go through current actions, and quarterly with the link midwife or Head of Midwifery. The MVP were well embedded into the service and the trust was open in its engagement with the MVP and women and birthing people using the service to drive improvement.

The MVP chairs told us there was good relationships with the trust and staff talked positively about the MVP group.

Maternity

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 given to women and birthing people antenatally. There were some statistically significant decreases in women and birthing people's satisfaction between 2021 and 2022 in regard to delayed discharges and access to staff for help and information.

Of those who had completed the survey, 173 people told us what was most important about their experience, and we saw 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.

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

Leaders held listening events with staff to address issues or concerns. An example of improvements made as a result of a listening event included 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.

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 an in-house maternity stop smoking service in the Wexham Park Hospital area maternity hub, health promotion and health education to improve genetic testing information, staff listening groups, community education sessions, and to work with close relative marriage families to provide genetic services to close relative coupled and families within the local area.

Maternity

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.

Staff were committed to continually learning and improving services. The service was committed to improving services by learning when things went well or not so well. For example, 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 for premature babies.

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.

Wexham Park Hospital were within the top 10 performing units for professional development and obstetrics training based on training indicators. These indicators were gynaecological training, obstetric training, and professional development. The hospital was highly commended for obstetric training and professional development and received a certificate by the Royal College of Obstetricians and Gynaecologists.

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 the quality improvement projects in 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.

Maternity

- 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.

Wexham Park Hospital maternity services

Action the trust MUST take to improve:

- The trust must ensure that all staff complete the required mandatory training. (Regulation 12)
- The service must ensure data showing poor performance is investigated, monitored, and acted upon in a timely way. (Reg 17)

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 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 there are bespoke guidelines in place for women presenting in advanced labour to the maternity assessment centre.
- The service should ensure maternal and baby readmissions are reported and reviewed separately.
- The service should ensure all staff have had an appraisal.
- The service should ensure incidents are graded appropriately.
- The service should ensure policies and guidelines are up-to-date, and there are effective processes in place to manage them.
- The service should continue work on completing guidelines for maintaining safe levels of inhalational nitrous oxide on the maternity unit.
- The service should consider the addition of a supernumerary co-ordinator to oversee staff and acuity across the whole maternity unit effectively.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors and 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.