Royal United Hospitals Bath NHS Foundation Trust

Frome Birth Centre (Frome Community Hospital)

Inspection report

Enos Way
Frome
BA11 2FH
Tel: 01373456629

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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 Frome Birth Centre (Frome Community Hospital)

Good

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Frome Birth Centre.

We inspected the maternity service at Frome Birth Centre 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.

Frome Birth Centre provides maternity services to the population of Bath, Paulton, Westbury, Warminster and the surrounding areas. The service books approximately 250 women and birthing people for care per year, and from March 2023 to November 2023 there were 53 births at the location.

The service had been closed for intrapartum care during the COVID-19 pandemic and had reopened for births in December 2022. It remained open during this time for antenatal care and clinics.

Maternity services include 2 birthing rooms with 1 birthing pool and a third room can be opened if required. Frome Birth Centre was open daily from 8am to 8pm and opened as-required during the night.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We had not previously inspected or rated maternity service at Frome Birth Centre as a standalone midwifery service. We rated maternity services as ‘good’ for safe and well-led.

We also inspected 2 other maternity services run by Royal United Hospitals Bath NHS Trust. Our reports are here:

Royal United Hospital Bath – https://www.cqc.org.uk/location/RD130

Chippenham Birth Centre - https://www.cqc.org.uk/location/RD102

How we carried out the inspection

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

We visited the birth centre which provides antenatal, postnatal and intrapartum services.

We spoke with 5 midwives and support workers, 2 women and birthing people. We received 3 responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 3 patient care records, 3 ‘observation and escalation’ charts and 3 medicines records.

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

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

Maternity

Good

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

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had enough midwifery staff.
- Staff assessed risks to women and birthing people, 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.
- 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 and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all staff had completed the adult basic life support training.
- We found 2 out-of-date policies and guidelines during inspection.

Is the service safe?

Good

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

Mandatory training

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

Midwifery staff received and kept up-to-date with their mandatory training. Service-wide data showed that 90.4% midwives and 90% maternity support workers had completed all mandatory training courses as of 27 November 2023, which met the trust target.

Maternity

The service provided Practical Obstetric Multi-Professional Training (PrOMPT) days to staff to encourage better communication and team-working across staff groups. Service data showed that 100% of midwifery staff and 97.5% support staff at Frome Birth Centre had completed the training, which was above the trust target of 90%.

Staff completed fetal monitoring training with 95% of staff attending the face-to-face training day, and 90.2% of staff had passed the assessment against a trust target of 90%. Compliance rates for newborn life support were 93% for midwives and 92% of support workers. A further 31 senior midwives across the trust had completed advanced newborn life support.

There was a maternity professional development study day which 94% of staff had completed, which was above the target of 90%, and manual handling training which included pool evacuation had been completed by 83% of midwives and 80% of support staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance was monitored monthly, using the Perinatal Quality Surveillance Tool and non- compliance of training was escalated to the quality improvement and patient safety lead in Family and Specialist Services. Staff said they received email alerts, so they knew when to renew their training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included skills and drills training, equality and diversity, information governance, and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

The service had a competency pack in place for Band 5 midwives to progress safely into a Band 6 role and competencies in intra-venous administration of medicines and fluids. In the community setting, the service provided practical skills and drills training each quarter. The most recent skills and drills at the time of the inspection were conducted in October 2023 and covered resuscitation in a home-birth setting, pool evacuation and manual handling scenarios.

In September 2023 the service launched the ‘Maternity Personalised Care and Support Planning training’ and ‘Maternity Anti-Racism Training’. Projections provided by the service showed that all midwives and maternity support workers would be compliant in both training topics by February 2024.

However, staff were not up-to-date with their adult basic life support (BLS) mandatory training. Records showed that 66% of midwifery staff had completed the adult BLS training against a trust target of 90%. Service leaders told us this was because updates had recently been changed from bi-annually to annually which had reduced compliance. Following the inspection, the trust data showed that 94% of midwives and 60% has completed the training as of 04 February 2024. The service had a trajectory and a training plan in place to bring overall compliance within target.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Maternity

Training records showed that 100% of maternity staff had completed Level 3 safeguarding adults training.

Training records showed that 94% of midwives and 88.1% of maternity support workers had completed the Level 3 safeguarding children and perinatal mental health training against a trust target of 90%.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. Staff could access a specific electronic system to identify any safeguarding risks linked to a woman or birthing person and staff could access the safeguarding team when they needed further support or guidance. Women with complex social factors were flagged on their electronic patient record and the safeguarding team.

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

Maternity services across the trust had a team of specialist midwives that were based within the service and caseload women and birthing people with complex social factors such as drug or alcohol abuse, current or recent domestic violence and mental health needs.

The specialist safeguarding midwives worked closely with external agencies within the local Integrated Care Systems (ICS) to ensure the service fulfilled its statutory safeguarding requirements. This include attending various safeguarding meetings such as case conferences and pre-birth tracking meetings to discuss unborn babies with Children's Social Care involvement for families who received support from social services.

Staff followed safe procedures for children visiting the midwifery led units.

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

The service showed learning from audits, local reviews, and serious case reviews, and this was shared with staff via a safeguarding newsletter and discussed during safeguarding supervision sessions and with groups of staff ad hoc. Recently identified learning was about the routine enquiry of domestic abuse, sharing information with parents around newborn crying and helping them to cope, and including information about fathers in risk assessments.

Cleanliness, infection control and hygiene

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

Maternity

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness, and audits from April to October 2023 showed 99% compliance for cleaning.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). The service audited hand hygiene for staff and data showed the service achieved 70% compliance in August and September 2023, which was low. Action plan was in place and feedback was provided to staff about non-compliant areas at the time of the audit. Service leaders recognised that the hand hygiene audits for Frome Birth Centre were consistently low. A request for detail on the reason for low results was made. The ward manager reviewed these results and had provided further training to staff and those carrying out the audits which resulted in a 100% score in November 2023.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

Environment and equipment

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

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

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was pool evacuation equipment available, a resuscitaire and an adult emergency trolley. Staff had enough home birth packs, a portable grab bag for emergencies and individual equipment needed for home visits. All equipment was serviced and had portable appliance testing completed.

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

There was a ligature risk assessment in place and completed in October 2023.

Assessing and responding to risk

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

Maternity

The Frome Birth Centre operated a low-risk maternity service and certain aspects of the maternity care pathway were not available on site. The service excluded induction of labour, caesarean section, or any major surgical procedure, inpatient care, transitional, and neonatal inpatient care. Staff risk assessed women and birthing people continually from the antenatal to postnatal period and there were clear criteria for use of the midwifery-led birth centre. Only women and birthing people who met the criteria for safe care used the service. The service also had clear criteria for use of the birth pool.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. The service was an early adopter of the national Maternity Early Warning Score (MEWS) for women and birthing people. We reviewed 3 MEWS records and found staff correctly completed them and had escalated concerns to senior staff at the main site. Staff completed a quarterly audit of MEWS charts to check they were fully completed and escalated appropriately. Audits for April 2023 to July 2023 scored 94% compliance overall. The service also used a nationally recognised newborn early warning trigger and track (NEWTT) tool to identify babies at risk of deterioration and escalated them appropriately. From September to November 2023, the trust NEWTT audit result showed 99.7% compliance.

The service monitored ambulance waiting times and shared this information with women and birthing people using the birth centre so they could make informed decisions about their birthplace choice. From July to November 2023, the average ambulance waiting time was 26 minutes from the service and 20 minutes from the women and birthing people home.

From November 2022 to October 2023, the average transfer rate from the service to the main hospital site was 26%. The top reasons for transfer were delay in progress, suturing and baby observation.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. There was a clear set of admission criteria for women and birthing people using the birth centre.

The birth centre facilitated personalised care planning sessions between midwives and women and birthing people to ensure they receive the best care.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The birth centre provided access to talking therapies for women and birthing people who needed it and there was a clinic held on site every 2 weeks.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Maternity notes were on a secure paper and electronic care record system used by all staff involved in care. Each episode of care was recorded by health professionals and was used to share information between care givers. Women and birthing people had access to their care record.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

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

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

There was a supernumerary birth centre lead on duty during the day who had oversight of staffing and capacity. There was a cross-site supernumerary shift coordinator or bleep holder on duty round the clock based at the Royal United Hospital Bath who had oversight of the staffing, acuity, and capacity on each shift including at Frome Birth Centre.

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

The service was staffed by 15.66 whole time equivalent (WTE) Band 3 to 7 clinical staff. This comprised of a Band 7 lead midwife, 15 Band 5 and 6 midwives, and 7 maternity support workers.

The service had low vacancy, sickness and turnover rates. Data showed that the service had 0% vacancy rate for maternity support workers and 0.91WTE (7.3%) vacancy for midwives as of 29 November 2023. There was an induction checklist in place for new staff to familiarise themselves with ways of working at the birth centre.

Leaders collected trust-wide data on staffing across all sites to complete a maternity safe staffing workforce review using a recognised national tool in 2022 and the final report was received in April 2023. The results showed a shortfall of 11.93 whole-time equivalent band 3 to 8 from the current funded establishment.

The trust maternity staffing report showed staff achieved 100% compliance in providing 1-to-1 care for women and birthing people in established labour.

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

Managers supported staff to develop through yearly, constructive appraisals of their work, and the appraisal rate was 93% which was above the trust target of 90%.

The education and retention team supported midwives. The trust wide maternity service had a large education and retention team which included lead midwives for recruitment and retention, quality improvement and education lead for staff and for students, a clinical skills facilitator, a lead international midwife, and a lead fetal monitoring midwife. The lead for maternity education and retention team worked across all sites. Staff and students spoke highly of the team and felt well supported.

The maternity education and retention team came under the quality improvement and patient safety team and included the quality improvement and education lead midwife, retention lead midwife and three clinical skills facilitators.

Maternity

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 paper records and found records were clear and complete. The service completed trust-wide maternity documentation audits and compliance for the 2023 audit was 81% against standards applicable to the midwifery-led birth centres. This was against the trust target of 90%.

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

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 3 prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines.

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

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 3 sets of records we looked at were fully completed, accurate and up-to-date.

The target for medicines management compliance was 90%. Compliance rates in November 2023 were 97.1% for midwives working at the birth centre.

Incidents

Maternity

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 25 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers reviewed incidents when they are reported so that they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. Managers reviewed incidents potentially related to health inequalities.

Managers and 'patient' midwife' shared learning with their staff about never events or serious incidents that happened elsewhere and in the service. Learning from incidents were cascaded to staff in various ways such as weekly newsletters, safety boards, posters, emails and a cloud-based team channel. Recent learning was identified around the process and criteria for referrals to paediatric services. Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Staff reported serious incidents clearly and in line with trust policy. The service had 1 open serious incident relating to Frome Birth Centre that had been open for more than 60 days. Leaders said an investigation extension had been agreed with the regional integrated care board and was due to be resolved by December 2023.

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

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good

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

Leadership

Maternity

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 birthing people 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. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Maternity services at Frome Birth Centre were managed as part of the Family and Specialist Services Division at Royal United Hospitals Bath NHS Foundation Trust. The lead midwife for Frome Birth Centre reported to the community matron, who reported to the director of midwifery. Wider service leadership was provided by a clinical director, and a divisional director of operations. There was a group of specialist midwives with strategic positions such as a mental health and an infant feeding midwife.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The community matron visited the community team weekly. The executive team visited wards on a regular basis.

The service was supported by maternity safety champions and non-executive directors, who had clinical backgrounds and invested in the improvement of the service. The chief nurse was the executive maternity safety champion for the service and upon taking this role, she had spent some time in the service and the infection control team to better understand it. She held regular listening events for staff and walk arounds to learn more about the service, the pressures faced and how this linked to national maternity recommendations and audits.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. The service was awaiting commencement of a national perinatal culture and leadership programme for which it was included in the last phase of the roll-out. The trust maternity senior leadership team was expected to attend educational sessions with 5 other national units to support promotion of positive culture change.

Leaders supported staff to develop their skills, take on more senior roles and take part in leadership and development programmes to help career progression. The senior leaders, including the safety champions, participated in the perinatal culture and leadership programme designed for the maternity services. The Band 7 midwife had completed a leadership course. All midwives in the service were assigned different roles and a rotation program was in place to shadow the Band 7 clinical lead to help develop leadership skills. This involved the rotation of the Band 7 midwives in the community and acute settings to various clinical areas to observe and understand the different pressure each area faced and recognise the importance of each other's role. This was in line with the trust values and behaviours to improve care, efficiency and communication.

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.

Maternity

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

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had revised the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The main areas of focus were workforce, health inequalities, improving quality and safety, digital transformation, personalised care and future-proof buildings.

The trust was looking at the sustainable long-term vision of the on-call rota for the community birth team as the number of births in the birth centres had reduced. Senior leaders were carrying out on-going engagement events with staff to get feedback and map out future plans for sustainability.

The trust wide maternity service recognised maternity workforce retention was key to delivering the vision and goals. It had presented a maternity and obstetrics workforce report requesting for ongoing investment in the service to meet increasing demands. There was a retention and recruitment strategy in place with a clear focus on staff wellbeing. For example, the service had employed a Band 7 recruitment and retention lead, there was a rolling Band 5 and Band 6 job advert, and the service increased the number professional midwifery advocates (PMA) to better support staff. There was also a new mental health and well-being leaflet for new starters introducing an inclusion team and an inclusion specialist midwife. The service had also started to roll out inclusion and diversity training for all staff, improved preceptorship and induction for new midwives, as well as pathways into midwifery for maternity support workers.

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

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued. 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.

Staff we spoke with were proud to work at the service and enjoying coming to work. Close team working, feeling listened to and safe culture were said to be a positive factor of working at the trust. Staff spoke positively about how the trust had invested and made improvement in the support given to the preceptor midwives.

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

Maternity

The trust wide maternity service had system in place to support staff following serious or adverse incidents. This includes hot debrief, professional midwifery advocate support, staff listening and psychological counselling service, and trauma risk management (TRiM) service.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also joined a training programme to educate all staff on how to identify and reduce health inequalities experienced by ethnic minority groups and provide better care. The trust wide maternity service had launched a 'milk project' in 2022 which provided infant feeding support in identified areas of deprivation, and a translation application, which had received positive feedback from staff and service users.

The service promoted equality and diversity in daily work. The trust wide maternity service had an equality, diversity and inclusion policy and process. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. There were no formal complaints reported for the trust maternity services between August and October 2023.

Results from the CQC maternity survey 2022 showed the service scored higher than the trust average in 5 out of 9 standards, about the same for 1 standard, and below or slightly below the trust average in 3 standards. The main concern staff voiced in the survey was around flexible working. Overall, the result was an improvement on all standards compared with 2021 results.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

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

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.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings including maternity services governance meetings which were open to staff, serious incident review meetings, safety champion listening events, divisional meetings and the board meeting. There was a clear chain of governance meetings that supported the flow of information between the ward and the trust board.

Maternity

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

Staff followed policies to plan and deliver. Staff received information about updated policies or guidelines via the guidelines updates newsletter. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. However, during the inspection we saw 1 out-of-date policy and guidance for staff on the 'transfer and discharge within maternity services', which was due for review in June 2021. We also observed an out of date version of the 'major obstetric haemorrhage' guidance in the service. This meant staff were not referring to the most up-to-date care pathways, posed a risk of errors or omissions in care. We escalated our concerns to senior staff, and we were reassured there was a new community birth unit major obstetric haemorrhage (MOH) guidelines that was recently implemented. Senior staff removed the outdated MOH guideline and replaced it with the flowchart from the new guideline which reflected the recent medicines changes.

The trust had introduced a monthly maternity specific executive performance review meeting to help leaders have a deeper oversight and governance on the maternity services. The trust maternity services governance was further strengthened by regular local maternity and neonatal system and integrated care boards visits. Senior staff told us the governance process in the service had been further strengthened in the last 2 years by the appointment of the community matrons, expansion of business support team, robust quality improvement and patient safety team and how information was shared at the trust board. The safety champions received a monthly report about the trust wide maternity services and were involved in the review and discussion on the learning from incidents. In 2022, the chief nurse commissioned a transformation team to complete a deep dive in the maternity service and engaged with other chief nurse colleagues to further understand the pressures in the maternity service and drive improvement.

The trust quality improvement and patient safety team included a lead midwife, quality improvement education midwife, retention lead midwife, 3 clinical skills facilitators, administrator, quality and patient safety investigator, quality audit midwife, 2 patient safety midwives, and 2 governance coordinators.

A clear audit plan for 2023 – 2024 was in place and included audits which were national audit drivers for example, Saving Babies' Lives, Ockenden, and Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE). MBRRACE was a national collaborative programme of work into maternal, stillbirth and neonatal deaths. For example, the audit plan included use of the National Perinatal Mortality review tool and identification and recording of risk status for fetal growth restriction.

Management of risk, issues, and performance

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

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Maternity

The service managed identified risks via a risk register and high-scoring risks fed into the trust-wide corporate risk register. Risks that directly related to the birth centre included IT support, staffing, medical gas exposure, incident reviews and the expiration of staff resources and clinical guidelines.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards on third- and fourth-degree tears, postnatal post-partum haemorrhage (PPH) of over 1500mls, patient experience, and smoking cessation at booking and birth. The service performed better than trust target on smoking cessation referrals and initial breastfeeding rate. The trust maternity dashboard showed that the service had high rates of PPH of over 1500mls and the trust was carrying out a 'deep dive' PPH audit completed in August 2023. Managers and staff used the results to improve outcomes and rates were below national average from October to December 2023.

Performance was monitored via the trust maternity services dashboard which included data on key indicators. The dashboard monitored the number of births in the birth centre, and it had met its birthrate target in 5 out of 12 months between November 2022 and October 2023.

The trust completed a Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 declaration of compliance to the board of directors in January 2023. The report identified that the service had achieved all 10 safety actions as part of CNST.

The maternity service had achieved the UNICEF baby-friendly initiative (BFI) silver status and was working towards achieving the gold status. The BFI is an initiative that supports breastfeeding and positive parent infant relationships by working with public services to improve standards of care.

Information Management

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

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure**.** The service had a digital midwife to support staff accessing electronic information systems. The digital midwife role was to provide digital tools to make processes smooth and safer. For example, the digital midwife regularly updated the information on the cloud-based team channel and had developed a specialist midwife directory online to support ease of communication.

Data or notifications were consistently submitted to external organisations as required. Leaders submitted data sets to the perinatal mortality review tool (PMRT), maternity dashboard, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries), Care Quality Commission and CNST.

Maternity

Women and birthing people had access to resources on the trust website, regional maternity and neonatal voices partnership website and the regional local maternity and neonatal system website. Information on the websites included various topics such as virtual tours, pregnancy, labour and birth, baby loss, and maternity and neonatal voices partnership. Staff told us that women and birthing people also had access to a joint regional maternity personalised care mobile application which provides information needed throughout pregnancy.

Engagement

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

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Leaders told us the Local Maternity and Neonatal System (LMNS) worked together to provide services for the regional population.

The service welcomed feedback from women, birthing people, and families. People could feedback to the service through surveys, complaints and through the local MNVP. In the last 12 months, the maternity services had included 2 patient stories in the trust board meetings and feedback had been used to drive improvement in the service. This includes a training video for staff around breastfeeding.

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

The trust maternity service had taken part in the National Maternity 2022 NHS Staff Survey. The result showed that the maternity services performed higher than trust average on 5 out of the 9 standards audited and similar to trust average on 1 standard. The trust maternity services scored below or slightly below trust average on 3 standards audited. This included morale, staff feeling 'safe and healthy', and working flexibly. The result showed there was an improvement from the 2021 result on all standards audited.

In the 2022 CQC Maternity survey, the trust scored the same as other trusts for 43 questions, however better and somewhat better than the national average for 8 questions.

Leaders understood the needs of the local population.

Leaders valued engagement with staff and had implemented and increased regular listening events with them and there was weekly Freedom to Speak Up clinics in place since July 2022. The service made several changes in response to staff feedback including higher rates of payment for on-call or bank shifts and implementing weekly payment for bank shifts. Leaders communicated with staff in various ways, and we saw plans for service transformation was displayed in staff rooms.

Women and birthing people we spoke to during the inspection said there was good communication from staff and the service. They said the service was easily accessible and were positive about the care they received at Frome Birth Centre.

We received 3 responses to our give feedback on care posters which were in place during the inspection. The responses were all positive, and themes included communication, staff attitude, good antenatal care and support and felt listened to.

Maternity

We spoke to 2 women and birthing people during inspection. All feedback received was highly positive and women and birthing people told us that were friendly, approachable and they had received safe and compassionate care. They were happy with the environment and car park.

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.

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

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. For example, the trust wide maternity diabetes team had worked collaboratively to implement a gestational diabetes digital app for women to equip them to manage their diabetes. The trust provided mobile phones for women and birthing people that were unable to have one to access the diabetes digital app.

The service had recently rolled out personalise care planning in October 2023 and found there was good uptake in discussions within maternity care records. The service was involved in a trial to inform care around perineal trauma following birth.

The Milk Project was piloted by maternity and neonatal services within the local maternity and neonatal system (LMNS). The aim of the pilot was to reduce health inequalities. Pregnant women and birthing people within specific local areas were offered additional support in pregnancy around infant feeding to help reach their feeding goals.

A community home birth team had been rolled out as part of a quality improvement project.

Outstanding practice

We found the following areas of outstanding practice:

- The trust maternity services recognised and understood women and birthing people groups and the additional challenges the women and families who accessed the service faced. Particularly around health inequalities, co-complexities and co-morbidities. The service had implemented several initiatives to tackle health inequalities, which included the milk project, gestational diabetes app and various staff trainings.
- There was a strong focus on engagement with staff, women and birthing people, maternity and neonatal voices partnership and local maternity and neonatal services in the region to drive improvement and provide safe and compassionate care in the service.

Maternity

Areas for improvement

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

Action the trust SHOULD take to improve:

- The service should ensure that guidelines, standard operating procedures, and policies are up to date and reviewed regularly.
- The service should ensure staff are up to date with the adult basic life support training modules.
- The service should improve staff compliance in the documentation audit.
- The service should continue to improve staff compliance in the hand hygiene audit.
- The service should continue to address the vacancy rates in the service and ensure there are enough staff on each shift.

Our inspection team

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