Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust

Bridgnorth Maternity Led Unit

Quality Report

Bridgnorth Community Hospital
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Maternity and gynaecology	**Good**

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Bridgnorth Midwife Led Unit (MLU) as part of a focussed inspection of Shrewsbury and Telford Hospital NHS Trust in November and December 2016. We visited the MLU unannounced on 1 November 2016.

We rated Bridgnorth Midwife Led Unit as good overall.

- There were systems in place to ensure the service was meeting the individual needs for women using the service. We found the service to be very responsive to the requirements of women using the service at all stages of the patient journey.
- The service provided a range of choices for women during labour, which included pain relief and hypnobirthing. Women told us they felt involved with decisions in their care and we saw women were supported emotionally throughout their pregnancy, birth and postnatally.
- We saw that staff were following good practice with infection prevention and control, the unit was clean and there had been no incidents of infections such as MRSA or CDiff during the reporting period.
- Staff were all aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the trust and that incidents were investigated appropriately.
- We saw that robust clinical governance and risk management arrangements were in place.
- Women and the family members we spoke with described positive care experiences. The results of the friends and family tests showed that over 97% of women who participated would recommend the service to their friends and family.
- Staff had access to and followed policies and procedures that were based on national guidance.
- The MLU was accredited with the UNICEF Baby Friendly Initiative (BFI). We saw that the unit promoted breastfeeding and the important health benefits of this for mother and baby.
- We saw that there were good systems in place to ensure good working relationships with other teams within the trust and with external organisations.
- We saw a positive culture within the MLU with strong leadership. Staff and women using the service were encouraged to provide feedback into how improvements could be made.

However:

- The MLU had experienced closure due to staff being required to support the consultant unit.

We saw areas of outstanding practice including:

- Staff at the MLU had participated in hypnobirthing training to provide women with further choice during their labour. However, there were also areas of poor practice where the trust needs to make improvements.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Maternity and gynaecology	Good		There were systems in place to ensure the service was meeting the individual needs for women using the service. We found the service to be very responsive to the requirements of women using the service at all stages of the patient journey. The service provided a range of choices for women during labour, which included pain relief and hypnobirthing. Women told us they felt involved with decisions in their care and we saw women were supported emotionally throughout their pregnancy, birth and postnatally. We saw that staff were following good practice with infection prevention and control, the unit was clean and there had been no incidents of infections such as MRSA or CDiff during the reporting period. Staff were all aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the trust and that incidents were investigated appropriately. Women and the family members we spoke with described positive care experiences. The results of the friends and family tests showed that over 97% of women who participated would recommend the service to their friends and family. Staff had access to and followed policies and procedures that were based on national guidance. We saw that there were good systems in place to ensure good working relationships with other teams within the trust and with external organisations. We saw a positive culture within the MLU with strong leadership. Staff and women using the service were encouraged to provide feedback into how improvements could be made. However, the MLU had experienced closure due to staff being required to support the consultant unit.

Care Quality Commission

Bridgnorth Maternity Led Unit

Detailed findings

Services we looked at
Maternity and gynaecology

Detailed findings

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Background to Bridgnorth Maternity Led Unit

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin, and mid Wales. Ninety per cent of the area covered by the trust is rural.

Deprivation is higher than average for the area, but varies (180 out of 326 local authorities for Shropshire and 96 out of 326 local authorities for Telford and Wrekin); 6,755 children live in poverty in Shropshire and 8,615 in Telford and Wrekin. Life expectancy for both men and women is higher than the England average in Shropshire but lower in Telford and Wrekin.

Bridgnorth Midwifery Led Unit (MLU) is based at Bridgnorth Community Hospital, a newly refurbished community hospital in south east Shropshire. The hospital is managed by Shropshire Community Health NHS Trust.

The MLU offers a friendly 'home-from-home' atmosphere with an emphasis on natural birth. The service is offered to women who will be at low risk of complications during labour, as there are no medical facilities. The consultant led unit is based at Princess Royal Hospital in Telford, 18 miles away.

The MLU has two labour rooms, a birthing pool and large bathroom with bathing facilities and relaxing coloured lighting. There were four beds available for women to stay with their baby post-delivery. The unit is staffed by a team of midwives and support workers, who also offer a community midwifery service to the local area.

There were 77 births at Bridgnorth MLU between November 2015 and October 2016. There were 270 births within the community midwife area. There were 116 admissions to the MLU, which included women who had chosen to give birth at the unit but were transferred to the consultant led unit and also those who chose to receive postnatal care as inpatients at the unit.

This inspection was a focussed follow up from the 2014 inspection. We previously rated this service as good overall.

We inspected this unit as part of our unannounced midwifery service inspection. During the inspection, we spoke with six members of staff and three women and their family members. We reviewed seven patient records. In addition to this, we reviewed information provided by the trust prior to and following the inspection.

Our inspection team

Our inspection team was led by:

Inspection Manager: Debbie Widdowson, Care Quality Commission

The team included two CQC inspectors.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

We carried out an unannounced inspection visit on 01 November 2016. We talked with staff and women on the ward. We observed how women were cared for and reviewed patients' records of personal care and treatment.

This was a focused inspection following up our findings from the 2014 inspection when the unit was rated as good in all domains.

Facts and data about Bridgnorth Maternity Led Unit

There were 116 admissions to the MLU between November 2015 and October 2016. This included women who had chosen to give birth at the unit but were transferred to the consultant led unit prior to labour and also those who chose to receive postnatal care as inpatients at the unit. There were 77 births at Bridgnorth MLU. Three women were transferred to the consultant unit during labour.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	Good

Maternity and gynaecology

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	**Good**

Information about the service

Bridgnorth Midwifery Led Unit (MLU) is based at Bridgnorth Community Hospital, a newly refurbished community hospital in south east Shropshire. The hospital is managed by Shropshire Community Health NHS Trust.

The MLU offers a friendly 'home-from-home' atmosphere with an emphasis on natural birth. The service is offered to women who will be at low risk of complications during labour, as there are no medical facilities. The consultant led unit is based at Princess Royal Hospital in Telford, 18 miles away.

The MLU has two labour rooms, a birthing pool and large bathroom with bathing facilities and relaxing coloured lighting. There were four beds available for women to stay with their baby post delivery. The unit is staffed by a team of midwives and women's services assistants, who also offer a community midwifery service to the local area.

There were 77 births at Bridgnorth MLU between 1st November 2015 and 31st October 2016. There were 270 births within the community midwife area. There were 116 admissions to the MLU, which included women who had chosen to give birth at the unit but were transferred to the consultant led unit and also those who chose to receive postnatal care as inpatients at the unit.

During the inspection, we spoke with six members of staff and three women and their family members. We reviewed seven patient records. In addition to this, we reviewed information provided by the trust prior to and following the inspection. We did not accompany community midwives on home visits.

Summary of findings

We rated this service as good because:

- There were systems in place to ensure the service was meeting the individual needs for women using the service. We found the service to be very responsive to the requirements of women using the service at all stages of the patient journey.
- The service provided a range of choices for women during labour, which included pain relief and hypnobirthing. Women told us they felt involved with decisions in their care and we saw women were supported emotionally throughout their pregnancy, birth and postnatally.
- We saw that staff were following good practice with infection prevention and control, the unit was clean and there had been no incidents of infections such as MRSA or CDiff during the reporting period.
- Staff were all aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the trust and that incidents were investigated appropriately.
- We saw that robust clinical governance and risk management arrangements were in place.
- Women and the family members we spoke with described positive care experiences. The results of the friends and family tests showed that over 97% of women who participated would recommend the service to their friends and family.

Maternity and gynaecology

- Staff had access to and followed policies and procedures that were based on national guidance.
- The MLU was accredited with the UNICEF Baby Friendly Initiative (BFI). We saw that the unit promoted breastfeeding and the important health benefits of this for mother and baby.
- We saw that there were good systems in place to ensure good working relationships with other teams within the trust and with external organisations.
- We saw a positive culture within the MLU with strong leadership. Staff and women using the service were encouraged to provide feedback into how improvements could be made.

However:

- The MLU had experienced closure due to staff being required to support the consultant unit.
- Staff completion of some topics included in the mandatory training programme was lower than the trust target of 100%.

The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.

Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- We saw that staff were following good practice with infection prevention and control, the unit was clean and there had been no incidents of infections such as MRSA or CDiff during the reporting period.
- Staff were all aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the trust and that incidents were investigated appropriately.
- The environment and equipment at the unit was all of a good standard and well maintained.
- Patient records were stored securely.
- We saw good standards of medicines management.
- There had been no never events or serious incidents during the reporting period.

However:

- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care. Staff did not always document the advice given to women over the telephone.
- The MLU had experienced closure due to staff being required to support the consultant unit.
- Only 59% of staff working at the unit had completed food safety and conflict resolution training which were mandatory.

Incidents

- No serious incidents were reported to the NHS strategic executive information system (STEIS) by Bridgnorth MLU between 1 November 2015 and 31 October 2016.
- Staff told us that investigations were conducted into serious incidents. If a serious incident occurred, an emergency meeting was held at the unit within 24-hours with all staff involved. This enabled any immediate actions to be identified. The subsequent report could be viewed on the intranet, which enabled them to be used for learning. We saw an example of a serious incident investigation on the intranet.
- Six incidents were reported from 1 November 2015 to 31 October 2016. Four of these incidents were reported as

the transfer of the woman to the Consultant unit. One was categorised as a delay in treatment and the other an incident where the wrong type of suture used. All of these incidents resulted in no harm.

- Maternal transfers are not recorded as an incident by the trust. They informed us this was because there is no NRLS code to support this type of incident. However, there were 14 women transferred to the consultant led unit between 1 November 2015 and 31 October 2016 and four of these were reported as an incident. If the service is not reporting all transfers as incidents an opportunity to learn from these events may be missed.
- Staff told us they were aware of how to report incidents and that they did so when appropriate. We saw staff using the electronic system and they showed us how to access this through the trust intranet. Staff told us that they received feedback from incidents they had reported through meetings, email updates and with regular contact with their manager.
- Staff told us they received information about trust wide incidents and provided examples of changes to processes that had been put into place as a result of learning from these. One example given was a woman who had been in the second stage of labour for longer than recommended. When investigated, it was highlighted that the staff had not realised the length of time and so a 'pause' stage was included for staff to review timescales during labour and act upon this appropriately.
- 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 Between 1stNovember 2015 and October 2016 the trust reported no incidents, which were classified as Never Events for Bridgnorth MLU.
- We saw minutes from the maternity governance meetings attended by the lead midwife for community services and saw that incidents were discussed. Staff told us they received feedback from these meetings and could also access the minutes. The service produced a monthly quality and safety report to promote cross unit information sharing.
- Due to capacity issues, there were no representatives from the MLU attending monthly perinatal morbidity and mortality meetings held at PRH. However, the manager received the minutes and told us they updated staff accordingly.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with described their obligations under duty of candour and, although they had not been required to put this into practice, were aware of when they would be required to act upon this. They had not participated in specific training that focussed on this but told us they had received information and could find further guidance.

Maternity safety thermometer

- The Royal College of Obstetricians and Gynaecologists (RCOG) launched the maternity safety thermometer in October 2014. The maternity safety thermometer measures harm from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological wellbeing.
- The trust did not utilise the maternity-specific survey. The head of midwifery told us they were aware of the maternity specific thermometer but that they felt that the service collected the same information elsewhere. We reviewed data that the trust collected and found that the trust collected some data via the maternity dashboard however, they did not collect and review harm in relation to postpartum haemorrhage, separation of mother and baby and psychological wellbeing.
- The service submitted data to the national NHS Safety Thermometer patient care survey instead. This measures harm from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism.

Cleanliness, infection control and hygiene

- There were no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile between November 2015 and October 2016.
- All areas of the MLU were visibly clean and well maintained. We saw cleaning logs that showed the department was cleaned daily.
- We observed all staff complying with the trust infection control policy. We saw staff wash their hands in-between patient contact and use hand gel and protective clothing. All staff were 'bare below the elbows'. We saw staff remind visitors to the department to use the hand gel prior to entering.
- We reviewed the birth pool and found this to be well maintained. Staff we spoke with knew the pool cleaning procedure, which was conducted daily as well as after each use.
- We saw the report from the infection prevention and control team inspection conducted in December 2015. The results of this showed that the unit was generally meeting high standards of cleanliness, infection prevention and control. However, it did highlight some actions to be taken. These included having hand gels at the point of care for patients, which we saw were now present by patient beds. We saw that the unit had addressed the other action points raised by the infection prevention and control team.
- A hand hygiene audit conducted in October 2016 showed the unit to be 100% compliant.
- Data requested from the trust showed that 65% of staff working at the Bridgnorth MLU had completed infection prevention and control training that was part of the mandatory training programme. The data also showed that 100% of staff had completed hand hygiene training.

Environment and equipment

- Midwives had access to the equipment they needed to confirm the health and well-being of mothers and babies. We saw that equipment had been maintained and stickers were applied to confirm that checks were up to date.
- We saw that the resuscitation equipment was kept in a central area of the department and was checked weekly. We saw that a tag was used to keep this sealed and when checked was logged and kept with the equipment.
- The resuscitaire (emergency equipment that is used to resuscitate babies) was stored centrally and was plugged in and ready for use. This was checked regularly to ensure it would be safe and ready for use if required.
- A newborn transfer pod was stored on the unit. This was checked and signed as in order daily by the WSA.
- To keep the area secure, a buzzer system was in place at the unit.

Medicines

- We saw that all medication was stored in locked cupboards on the unit.
- Controlled drugs were checked at each shift changeover and keys were handed over. Staff kept a record of these checks and we saw this during the inspection. We saw that all of the controlled drugs were within expiry dates and stored appropriately.
- A controlled drugs audit was conducted in August 2016. The results of this showed the MLU to be compliant with good practice guidelines.
- There were no temperature checks conducted of the room where medicines were stored however, we did see that those medications that would be affected by temperature were kept in a refrigerator. The refrigerator was clearly labelled for this purpose and temperature checks were conducted daily.
- For women who were attending the MLU for post-natal care following delivering their baby at a different hospital site, their medications would be brought with them.

Records

- The MLU used a combination of paper based and electronic patient records. The paper-based information kept at the unit held key information and the patient held their main notes.
- The trust conducted a records audit in November 2016, which included five sets of patient records from Bridgnorth MLU. A total of 45 records from other areas across the trust were also included. The results of the audit showed that records were appropriately kept. However, improvements were required with ensuring the patient's name and unit number were consistently uses and that entries were in chronological order. There was also a recommendation to review storage arrangements for assessments and investigations.
- We saw that patient's paper records were stored securely in a locked room away from public view.

- We saw that records were maintained in an orderly fashion with a system that staff told us was easy to navigate and worked for them.
- We reviewed seven patient records, which included information about test results, scan information and discussions with the women in their care. The notes were legible and current.
- We saw that risks were assessed during appointments and documented clearly in the patient records.
- There were no treatment charts available during the inspection however we did see a record of any medicine provided during labour on the delivery record.

Safeguarding

- Arrangements were in place to safeguard women and babies from abuse and reflected safeguarding legislation and local policy.
- At the time of the inspection 100% of staff had completed safeguarding adults and safeguarding children level 2 and 3 training.
- Staff we spoke with were able to describe the trust's safeguarding policy and reporting procedure. We saw flow charts and information displayed for staff to make quick references to when required.
- We saw there were posters with information about domestic violence on the back of the patient toilet door. The manager of the unit told us the location of the posters had been considered carefully as this was the area least likely for a partner or visitor to attend with the woman.
- The trust told us and we saw evidence that mandatory safeguarding training included child sexual exploitation, female genital mutilation and domestic abuse awareness and encouraged staff to access further training through the Local Safeguarding Children Board.
- Support plans were put into place to support women with additional needs including referral to the Supporting Women with Additional Needs (SWAN) team. This team visited the unit to ensure their needs and requirements were being met.
- Staff told us they felt very well supported by the safeguarding lead for the unit who attended the monthly SWAN meetings.

Mandatory training

- We saw the maternity-specific mandatory training guideline, which included the training needs analysis for 2016-2019. This detailed what was required for midwives, women's support assistants (WSAs) and medical staff and how often. There were 35 modules in total and included appropriate modules such as obstetric emergency multi-disciplinary skills drills, a fetal monitoring package, newborn life support skills, early recognition of the severely ill woman, post-operative recovery skills and neonatal stabilisation. Compliance rates for all modules were provided at service level only and not broken down by unit. Electronic fetal monitoring was recorded at 80% and care of the severely ill women recorded as 95.8%. Neonatal stabilisation training was recorded as 82%. The target was set at 80%.
- Care group governance meeting minutes for November 2016 showed that 84% of midwives, 74% of Women's Services Assistants (WSAs) and 86% of obstetric medical staff were up-to-date with obstetric emergency skills. The target was set at 80%.
- During 2016, the unit undertook five live skills drills including Cord prolapse and neo-natal resuscitation.
- There was a statutory mandatory training programme which included 16 topics such as patient moving and handling, adult basic life support, slips trips and falls and equality and diversity. This was completed during a 'three day' annual mandatory training programme.
- The trust target for staff completion of mandatory training was 100%. At the time of the inspection, the unit level was 65%. This varied between topics as safeguarding and information governance and making every contact count were at 100% however, conflict resolution training was at 59%, hand hygiene and food safety were at 65%.

Assessing and responding to patient risk

- At each antenatal appointment women's individual risks were reviewed and reassessed.
- The trust had a clear policy on antenatal clinical risk assessment, setting out a colour coded criteria for women who were suitable for low (green) risk care (delivered by community midwives and MLU births), those who were medium risk and required closer monitoring (amber) and those classed as high risk (red) and needed care under a consultant. Midwives were able to describe this policy and confirmed that risks were discussed with women at each stage of the process.
- A local survey of all women who gave birth at the trust during September 2016, asked what women were

informed about when choosing where to have their baby. The survey showed that 91.7% of women were informed that MLUs were staffed solely by midwives, 97.3% were aware that if a problem arose during labour they may be transferred to the consultant unit and 82.9%, were aware of how long it would probably take to transfer from the MLU to the consultant unit.

- When a woman reached 36 weeks of pregnancy, a final decision on the place of delivery was made. Decisions were made involving midwives at the MLU and the woman.
- Only women categorised as low risk were able to deliver their baby at the MLU or their own home. Those with additional risks would be advised to deliver their baby at the consultant led unit.
- For women who chose to deliver their baby at home against medical advice, two midwives would attend the entire labour to support and provide professional advice throughout. An on call system was in place for the time around the due date in order to facilitate this.
- Staff told us and we saw in patient records that the Modified Early Obstetric Warning Score (MEOWS) was used to monitor women during ante-natal care and post-delivery, which would help detect the ill or deteriorating woman.
- Staff told us and we saw recorded in patient notes that the Newborn Early Warning Score (NnEWS) was used at delivery and then again two hours later. This would provide indicators of any deterioration with the baby. Staff told us that if the baby showed any signs of concern they would use the NnEWS assessment again but otherwise would not do so.
- We saw the trust's perinatal sepsis guideline 'Sepsis related to the antenatal, intrapartum and postnatal period' due for review in September 2016. This included the nationally recognised 'Sepsis 6' care bundle and the maternity sepsis screening tool, in line with Sepsis Trust UK guidance.
- There was a policy and procedure in place for transfer of deteriorating patients. Midwives followed the trust policy for the transfer of women in labour to the main site including the management of women or babies who showed signs of deterioration and required additional care. Women were transferred by ambulance from the MLU to the consultant led unit at Princess Royal Hospital with a telephone call made to inform the receiving unit.
- Staff gave recent examples of this procedure being used and told us that it worked well and that they were well supported by the consultant unit in these situations. We also saw information displayed on notice boards with the procedure outlined clearly.
- Data provided by the trust showed that between 1st November 2015 and 31st October 2016 there were 14 transfers of women from Bridgnorth MLU to the consultant unit intrapartum. Four of these were due to delay in the first stage of labour, four were due to delay in second stage of labour. One transfer was due to antepartum haemorrhage (APH) which is bleeding from or in the genital tract. Three transfers were due to meconium stained liquor, one because of long latent phase and one for 'other' maternal reason.
- We were told that the medical staff from Princess Royal Hospital were supportive and available at all times over the telephone for advice and guidance. Scans and fetal measurements could be faxed to the consultant led unit for review and second opinions.
- The trust had completed a service wide review of transfers by ambulance between April and September 2015 to ensure that women were being transferred appropriately. The review concluded that women were not being unnecessarily transferred and outcomes for those who were transferred were good.
- The trust had a policy in place for the transfer of postnatal women from the consultant led unit to the MLU. The policy states that after an initial assessment following birth, women can be transferred if she and her baby meet the criteria. The criteria excludes women who were less than 24-hours post caesarean section and/or were not mobile and babies who had not fed in the first 12 hours, if they had neonatal jaundice that requires medical treatment, babies with a fetal abnormality, requiring nasogastric tube feeds or with a temperature of less than 36°C. There were 133 women transferred for post natal care between 1 November 2015 and 31 October 2016.
- The trust told us it does not currently audit the transfer of women from the consultant unit to the MLU as this is part of the planned process, however, they are planning an audit of handover of care between the CLU and the MLU during 2017/2018 as part of their audit programme.
- Handovers took place at the start of each shift. We observed a handover and saw that risks of in-patient's were discussed and time given for further questions or guidance to be provided.

- Staff were able to tell us about the procedure to evacuate a mother from the birth pool in the case of an emergency.
- During the inspection, we observed telephone discussions with women who had called the unit for advice from a midwife. We saw that two out of three conversations had been recorded in the patient notes, however one discussion had not been written down. Failure to document the concerns raised by women and advice provided essential information about a patients wellbeing were not identified and appropriate actions taken. This would provide robust evidence of advice given at the time.
- Staff participated in regular drills to practice and update their skills with emergency procedures such as resuscitation. We saw equipment to do so was available and staff told us they did have the opportunity to do this on a regular basis.

Midwifery staffing

- The trust had recently commissioned a 'Birth-rate Plus' workforce planning review and the results were expected in early 2017. The National Institute for Health and Care Excellence (NICE) endorsed this tool. Birth-rate Plus will determine the trust's maternity staffing requirements to ensure safe care.
- There were 10 midwives working at the unit (seven whole time equivalents) and one full time Sister/Charge Nurse.
- The planned staffing levels were a minimum of one midwife on the unit at all times. Staff worked 12-hour shifts to cover these requirements. In addition to this, one midwife was on call during the night (and would be called to assist with the second stage of labour). If a home birth was planned, a rota was put into place for two midwives on call for up to four weeks to ensure sufficient staffing.
- There were a total of seven (five whole time equivalents) Women's Services Assistants (WSA) who provided additional support in the unit according to their training and designated responsibilities. There was one WSA on duty at all times and staff worked 12-hour shifts to provide cover. There was one student midwife based at the MLU on placement from Staffordshire University.
- In addition to staffing the unit, the midwifery team provided a community service, covering a large rural area. This was provided by one midwife. Three days a week there was an additional community midwife who ran clinics at the unit.
- An acuity tool was used to record staffing levels and the manager sent reports monthly for this to be reviewed.
- Midwives told us they provided one to one care in labour and were always supported for the delivery by the on call midwife.
- The manager informed us that the unit had required to be closed twice in the twelve months prior to the inspection due to the consultant led unit requiring support from midwives and so the unit was unsafe for women to attend in case of requiring evacuation. Women who were due to attend the unit were informed of closures and given information and options to attend other midwife led units across the trust.
- Staff told us that they were called out to assist with home births and women during the second stage of labour at the unit. Due to the small number of staff based in the department this meant that midwives were often on call and then could have been working during the night when on shift the following day. The trust did not provide data to reflect how often this was occurring.
- The manager of the unit told us staff were reluctant to take time back during the morning for rest due to the impact this would have on their colleagues on shift.
- The staff and manager told us their concerns about safety in regards to staff being tired at these times had been escalated to senior managers. They had been told that and informed that processes were being considered to support staff with taking back time appropriately.
- The chief executive of the trust had informed staff in February 2016 that a clear guideline had been set for staff to only be on call for the MLU at which they were based. However, staff raised concerns with us that they were often called out to support the consultant led unit in Telford and this meant they were out for longer hours. This impacted on the staff's availability for the MLU the following shift. Working Time Rules state that staff should have a consecutive 11 hour rest time within any 24 hour period, we saw that staff were not always having this.

Maternity and gynaecology

- Formal handovers took place with staff finishing their shift and those starting theirs. We observed a handover and saw that each woman was discussed, her care reviewed and any updates or relevant information given.
- Staff told us that they felt sickness was well managed within the unit and that there did not seem to be issues with staff requiring long periods of sick leave. Between October 2015 and November 2016 the average sickness rate was 2.4%.

Medical Staffing

- There were no medical staff working at the unit. If midwives had concerns about a woman or baby they would seek guidance from the labour ward at the Princess Royal Hospital and, where necessary, follow protocols for transfer to the hospital.

Major incident awareness and training

- The trust had a major incident and business continuity plan in place and staff were aware of how to access this information.
- Fire safety awareness training was included as part of the staff mandatory training course.
- Staff told us fire drills were conducted as part of the community hospital programme and that two evacuations had been executed without issues in the twelve months prior to the inspection.
- A lone worker policy was in place and staff were able to access this through the trust intranet. Staff told us that when working in the community midwives would take their own mobile telephone as well as the unit phone, they would have a list of the addresses where they were going which would be available at the unit. This meant that if staff at the unit were concerned about them or if they did not return when expected they would try to contact them.
- Staff told us they did have safety devices available however, these were no longer in use and they were waiting for replacements.

Are maternity and gynaecology services effective?

We rated effective as good because:

- Staff had access to guidance, policies and procedures that were based on national guidance.
- Women were able to choose from various methods of pain relief including water in a bath or birthing pool where available.
- The MLU was accredited with the UNICEF Baby Friendly Initiative (BFI). We saw that the unit promoted breastfeeding and the important health benefits of this for mother and baby.
- Staff were well supported with training, appraisals and supervision to ensure that they were competent and up to date with their skills.
- We saw that there were good systems in place to ensure good working relationships with other teams within the trust and with external organisations.

Evidence-based care and treatment

- We saw that staff had access to guidance, policies and procedures through the trust intranet. A staff member who worked at the unit had been involved in developing trust guidelines and they had kept colleagues up to date with updates.
- The trust employed a guideline midwife responsible for co-ordinating policies and procedures for maternity. Records for November 2016 showed 92% of guidelines were up-to-date and those that were out-of-date had action plans and were due to be presented at the next maternity governance meeting.
- From our observations and discussions with staff, we saw that women were being cared for in accordance with NICE quality Standard 190 Intrapartum care. This included for example, having a choice as to where to deliver their baby, choice of care throughout labour and monitoring during labour.
- We saw that in line with NICE quality standard 22, women were given the choice to have screening tests for complications of pregnancy. Antenatal care was provided for women up to 42 weeks of pregnancy.
- We saw that postnatal care provided for women was in line with NICE quality standard 37. This included care and support given to the woman, baby and those close to them. We saw staff supporting women with breastfeeding and caring for the baby on the unit.
- There was a variety of information based on research and NICE guidance available to inform women using the service of a variety of options that could be chosen during labour.

- The service audited compliance with NICE guidance on an annual basis.

Pain relief

- Women were offered access to various sources of pain relief such as entonox and pethidine. We saw Entonox leaflets available that provided information on the methods of pain relief.
- A birth pool was available on the MLU so women could use water emersion for pain relief in labour.
- Women we spoke with felt their pain had been well managed.
- Staff told us they reviewed pain relief regularly for its effectiveness and made changes as appropriate for the individual needs of the women.

Nutrition and hydration

- The MLU was accredited with the UNICEF Baby Friendly Initiative (BFI). We saw that the unit promoted breastfeeding and the important health benefits of this for mother and baby. We saw information posters available and staff told us they discussed this with mothers at all stages of pregnancy and post-delivery of the baby.
- The unit was able to invite new mothers to attend the unit for breastfeeding support and if they chose to, could stay overnight to have continued support throughout the night hours.
- Women were able to choose food from a varied menu and had access to snacks and hot and cold drinks in a patient lounge. We saw staff offering women drinks throughout the inspection.
- A woman we spoke with told us the food was pleasant and that her partner had been offered food and drinks during the labour and afterwards.

Patient outcomes

- In 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030, with a 20% reduction by 2020. The trust had recently 'signed up to safety' to contribute to the NHS England ambition to improve maternity outcomes.
- The midwife to birth ratio for the trust from April to November 2016 was 1:30 and was in line with the recommended target of 'Birth-rate Plus'. The data provided was trust-wide and not broken down by unit. We were unable to determine the midwife to birth ratio for the MLUs.
- The trust wide percentage of women having their babies at home was 1.3% as of November 2016 and this was the percentage for 2015/16 overall. This was just below the national England average for home births of around 2%.
- Maternal smoking status at the time of delivery data showed that the trust had a rate of 16% from April to November 2016 and 15% for 2015/16, which was better than the locally agreed target of 20%.
- A trust wide audit was conducted involving 43 mothers who were interviewed about the breastfeeding support they had received while under their care. Questions included the support provided by staff at birth, learning about breastfeeding, food and fluids provided other than breastmilk, relationship building between mother and baby and antenatal care. The results showed that for most of the areas the trust achieved above 90%; mothers stated they had received adequate support. The percentage of babies provided with supplements to breastmilk should be below 20% however the trust had supplemented 24%.The score for mother's being shown how to hand express breast milk only just passed with a score of 81%.
- During 2016, the service introduced a maternity dashboard that identified performance and key patient outcomes benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard:
- Bridgnorth MLU demonstrated 100% normal delivery between April 2016 and November 2016 which was better than the local target of 85%.
- Data showed that during the same time period 6.4% of women required manual removal of a retained placenta which was higher than the expected range of 0-2%.
- Rates of third or fourth degree tears were 4.3% which was within than the expected range of 0-5%.
- There were no stillbirths reported for this unit during April 2016 and November 2016.
- The national target for booking appointments was 12 weeks and this was being achieved consistently.

Competent staff

- The service has a policy and procedure in place that set out the process for rotation of midwives in order to

assist in supporting staff to gain experience in key areas of Midwifery and to refresh skills. A list of those rotating is produced every April and October. The service undertook a survey of midwives in May 2016, of the 213 respondents across all areas, 70% of midwives said they thought their clinical practice was enhanced.

- The trust provided us post inspection with evidence of newly developed midwifery competencies for all employed midwives. This was to commence in February 2017 and we saw the agenda for this programme. This included the importance of midwifery competencies, accountability, implementation and monitoring of these competencies.
- Data provided showed that 13 out of 16 (81%) of staff had received their appraisal at the time of the inspection which was a lower rate than the trust target of 100%. Staff told us they found this a supportive and useful process.
- Staff told us they had regular supervision and that they could access time with a supervisor of midwives, as they required.
- A preceptorship package was in place for newly qualified midwives, which included a specific structured rotational programme. The rotation process ensured that the midwifery workforce maintained their skills and provided flexibility with service provision.
- There was an induction pack prepared for new members of staff to work through. Staff told us that the process included a walk around the unit, completion of mandatory training and at least two weeks supernumerary period.
- Staff told us they were supported to complete training and keep up with competencies for skills. There was equipment available for staff to practice skills such as perineal repair.
- Four midwives working at the unit had recently completed a hypnobirthing training course to be able to support women who chose this option during labour.

Multidisciplinary working

- Staff described a positive working relationship with the consultant led unit with the other midwifery teams and the medical team at the hospital. They told us that transfers and referrals to the consultant led unit worked well and that the working relationship was very effective.
- If staff at the MLU had any concerns during antenatal checks they would ring the early pregnancy unit or labour ward at Princess Royal Hospital. They described a positive working relationship and could refer women to be seen and could arrange urgent scans if necessary.
- There were physiotherapy clinics operating in the same building as the MLU. Staff told us that where possible they would see women for checks the same day as their physiotherapy appointment and would work alongside each other to assist women.
- Community midwives held clinics at GP practices and told us this worked well, there was good communication with GPs and other practice staff and so information could be shared appropriately. Staff also described positive working relationships with health visiting teams.
- We saw information available for staff to refer women to a specialist midwife at the Shropshire Women's Centre as part of the "improving women's health" scheme.
- Staff told us there was an effective 'early help' process if there was the requirement for social work involvement.

Seven-day services

- The MLU was open 24 hours per day, seven days per week.
- An on call system was in place to ensure that for women reaching the second stage of labour during the night a second midwife would attend for the delivery of the baby.

Access to information

- We saw that there was trust guidance available for staff on the intranet. This system was accessible and staff were able to show us where to find policies and protocols as well as trust wide updates.
- There was a folder available on the unit with information of meeting minutes and notices which identified the latest good practice and any updates to policies and procedures issued throughout the service and trust where appropriate.
- Staff told us that there were at times issues with accessing systems however; this did not usually affect their ability to work effectively.
- We saw newsletters from the Staffordshire, Shropshire and Black Country Newborn and Maternity network. The newsletters provided updates and information for midwifery services across these areas.

Maternity and gynaecology

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they always provided as much information as possible and then gained consent from women prior to delivering any care or examination.
- Staff showed good awareness of the procedure to follow regarding the Mental Capacity Act.
- From the seven records we reviewed, we saw that consent was appropriately recorded.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Women and the family members we spoke with described positive care experiences.
- The results of the friends and family tests showed that over 97% of patients who participated would recommend the service to their friends and family.
- Women told us they felt involved with decisions in their care.
- We saw women were supported emotionally throughout their pregnancy, birth and postnatally.

Compassionate care

- The trust participated in the NHS Friends and Family survey. Between October 2015 and September 2016 the results for the antenatal care survey showed that 97% of women who participated would recommend the service to their family and friends.
- During the same time, the results for women who had used the trust maternity service to give birth showed 100% would recommend it. The results for women who had received postnatal care were 99%.
- We observed staff interacting with women in their care in a caring and compassionate manner.
- We spoke with one woman who said, “Everyone has been really nice”. We saw thank you cards from women and families that contained comments such as “fantastic care from all staff to mum and baby”.
- We spoke with one woman and her partner attending an antenatal appointment who were very positive about the care received from staff at the MLU. The patient had experienced several previous miscarriages and had a complex past medical history. Although the patient was assessed as high risk and so was due to give birth on the consultant unit she had received antenatal care at Bridgnorth MLU. We saw that staff spent time to provide information and reassurance about the induction procedure she would have the following day.
- Midwives would care for the baby to give the mother time to go to the lounge area and play with their older children where toys and activities were provided.

Understanding and involvement of patients and those close to them

- Both women we spoke with told us they had been involved with decisions around care and treatment.
- Comments on the thank you cards we saw included “outstanding care and ongoing support”. We spoke with a woman who had required transfer to the consultant unit following the birth of her baby. She told us that the staff had given full information about what would be required and that she did not feel hurried or panicked, due to the way they discussed this with her.

Emotional support

- We spoke with a woman who had delivered her baby at the MLU. She told us she had received one to one care during the labour and had a midwife with her when she was required to transfer to the consultant unit.
- We saw a woman attend the antenatal clinic and expressed that she was feeling upset and emotional at the time of the appointment. We saw a midwife reassure her and offer time to talk.
- Bereavement counselling was available for staff to refer women to if they required following the loss of a baby.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Systems were in place to ensure the service was meeting the individual needs of women using the service.

- For those who were particularly vulnerable, there was a Supporting Women with Additional Needs team who met frequently to ensure that all protocols were followed and information shared effectively between various teams as appropriate.
- Staff were aware of the information women would require if they wanted to make a complaint and were clear of the procedure. There were systems in place to ensure that there was learning from complaints and staff provided examples of changes to practice as a result of concerns raised.

Service planning and delivery to meet the needs of local people

- The MLU promoted a ‘home from home’ experience where partners were made welcome and could access facilities as well as the women.
- There were 77 births at Bridgnorth MLU between November 2015 and October 2016. Midwives based at the unit also provided community care to the local area ; there were 270 births within the community midwife area during the reporting period. There were 116 admissions to the MLU, which included women who had chosen to give birth at the unit but were transferred to the consultant unit and those who chose to receive postnatal care at the unit.
- Antenatal and postnatal appointments were held at the unit, GP practices or home of the women using the service and midwives told us they tried to be as flexible with appointments as possible.
- Parent craft classes were held in the health centre situated in the building next to the MLU. This consisted of a five-week course and additional online course. Health Visitors ran this and the midwifery team had input by delivering some of the sessions.

Access and flow

- Women could access the maternity services for antenatal care via their GP or by contacting the community midwives directly.
- Admissions in to the unit were arranged at the first booking appointment. Re-admissions were booked through the consultant unit or the GP.
- The community midwives covered a large rural area and so would encourage women to attend the MLU for their appointments for post-natal checks as they would not have the capacity to attend to everyone with the current staffing levels.
- Clinics were held at the MLU three days per week with an additional community midwife. Staff told us the community clinics were very busy and that although they should finish seeing women at 4:30pm they would often be making appointments for after this time in order to ensure everyone had been seen.
- Post-natal follow up care was arranged as part of the discharge process with community midwives.
- Women were able to receive care at the unit if they were classified as being low risk and/or if they opted for support following the birth of their baby. Staff told us that it was rare that women were unable to have a place at the MLU. If there were occasions where a place was required the manager would discuss this with the woman who was deemed to require the least support in order to provide the capacity.
- Staff told us that upon discharge, women were provided with information and guidance notes.

Meeting people’s individual needs

- Staff told us that women were supported to make choices about the place to give birth throughout their antenatal appointments. We saw a midwife showing a patient around the unit and explaining the use of the various facilities.
- There were specific risk factors in place, which required consideration and would lead midwives to advise a hospital birth rather than a home birth or the MLU.
- Visiting times were 9am to 8:30pm for partners and their children. For all other visitors the times were 2pm-4:30pm and 6-8:30pm. There were protected mealtimes in place.
- We saw evidence that for women with additional needs, specific plans were put into place to support them as well as referral to the Supporting Women with Additional Needs (SWAN) team. This team held regular meetings on the unit to ensure any requirements were met.
- Staff had access to a telephone translation service for patients whose first language was not English. They told us they could also book a translator to attend in person if necessary.
- Information leaflets were available in other languages through the trust intranet.
- We saw staff asking women about special dietary requirements, which included if they would prefer halal food.

Maternity and gynaecology

- Staff told us they had the time to support and teach parent craft with women with learning disabilities. We saw a folder containing illustrated information for women who may find it difficult to read or to understand verbal communications.
- Staff told us they ensured they were familiar with woman's birth choices prior to caring for them and that in the event that these changed they would try to assist the women to have the closest experience as possible to their plan. An example of this was a woman who had delivered her baby at the MLU however required transfer to the consultant unit for manual removal of the placenta. Prior to the transfer the staff on the unit supported her with breastfeeding her baby and having the experience she had wished for during the immediate time after the birth.
- Staff told us they were supportive of women with all choices they made. If a woman had opted for a home birth against medical advice, there was an on call system in place for two midwives to attend the entire labour to provide as much support as possible.
- There was a large bathroom available for use, which had different coloured lighting to create a relaxing atmosphere for women. There were facilities available for music of the woman's choice to be played.
- There was a birthing pool available for women who chose to use it. A risk assessment was completed prior to use and if it was suitable for the women to use they would be cared for in the pool environment.
- Staff on the unit had completed a course to be qualified in providing support for patients with hypnobirthing. Midwives told us they provided information about this to women and they could opt for it as part of their birthing plan.
- We saw that there was a chaperone policy in place and there was information displayed for women to have awareness that this was available.

Learning from complaints and concerns

- We saw that staff had access to the trust policy for complaints on the intranet and knew about the Patient Advice and Liaison Service (PALS), which supports patients with raising concerns. There were posters with this information displayed on the unit.
- Staff told us that they received very few complaints and that if any women raised a concern or issue whilst at the unit they would apologise, try to find resolution and escalate to the manager of the unit. The manager informed us that she would provide the information for women to make a formal complaint if they remained dissatisfied.
- The MLU had received two formal complaints between November 2015 and October 2016. One of these related to inappropriate advice being provided over the telephone. The other was in regards to a woman requiring to move three times due to the closure of Bridgnorth MLU.
- Due to informal complaints raised by women about long waits, the MLU had recently made changes to the time patients were booked into clinics and for parent craft sessions. Staff told us that this had led to reductions in waiting times.
- Staff told us that a woman had raised concerns about the visiting times and felt that there had been differences in how others were able to receive visitors. This resulted in the unit providing all women with the visitor policy as they arrived to ensure that the times and arrangements were clear. They said there was still flexibility when required but this felt more fair.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- Staff demonstrated the values of the trust and it was clear they were working towards the philosophy and vision of the MLU.
- There seemed to be a positive culture within the MLU with staff and women using the service encouraged to provide feedback into how improvements could be made.
- The staff described strong and positive leadership from the unit manager and across the service as a whole. They felt they could raise any concerns and that issues would be dealt with appropriately if they did so.
- We saw that robust clinical governance and risk management arrangements were in place.

Leadership of service

- The care group management team consisted of a care group director, a head of midwifery (HoM) and a care

group medical director. The HoM and the care group director came into post in September 2016. There was a lead midwife for community services who was responsible for all MLUs within the trust. There was a manager at the unit responsible; for it's day to day running, who reported to the lead midwife. Although these management arrangements were in place to ensure joined-up working, we saw that the unit mostly operated independently of the consultant led unit.

- The Head of Midwifery for the trust had been to the unit and staff told us she was approachable. They felt they could raise issues through the management process or directly if appropriate. She also issued a monthly newsletter across the trust to keep staff up to date with maternity department information.
- Midwifery staff spoke positively about managers of all levels in the service and told us they were visible and they felt well supported.
- There was a notice displayed with acknowledgment of the staff's increased workload and thanking them for their hard work as well as encouraging their ideas for how to improve the service from the head of midwifery.
- Staff told us they felt the trust executive board were visible, they were aware of who they were and knew that some members had been to the unit.

Vision and strategy for this service

- The philosophy of the MLU was displayed in the unit; "we aim to support you in your choices and tailor the care we give around your individual needs in a safe, warm, welcoming and supportive home from home environment." Staff demonstrated that they were working towards this philosophy and it was clear they were very patient focussed.
- A full review of the maternity service across the trust was in progress. The purpose of this was to consider ways the service could be developed and improved. Midwives were aware of the possibility of future reorganisation of the service and felt like this would be positive for the service.
- The staff told us the vision for the unit included extending services such as water births and offering more choice in labour for women.
- The trust values were "proud to care, make it happen, we value respect, together we achieve". These were displayed on the unit; staff were aware of these and displayed them in their work and attitudes towards their role working for the trust.

Governance, risk management and quality measurement

- There was a clear governance committee structure with direct reporting from the MLU to the care group leadership team.
- The care group governance committee received regular reports on quality performance, patient experience, serious incidents, complaints, audit and risk. These reports included information from the MLUs. We saw evidence of this in meeting records.
- The MLU did not have its own local risk register. All risks were recorded on the care group risk register, which was reviewed and updated monthly. We saw that the risk register identified and reflected the risks at MLUs such as IT system failures. Risks and responsible owners were appropriately assessed, reviewed and escalated.
- During 2016, the service introduced a maternity dashboard that identified key performance indicators and patients outcomes for each MLU, benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard.
- During this inspection, we found that the trust were taking previous failures seriously and saw evidence of some changes taking place across all the MLUs. We saw that the service recognised they were in a transition period and that continued improvements were required. An external review of governance processes, was in progress at the time of our inspection. Senior managers told us this was because they recognised there was potential to make improvements.
- All incident forms were reviewed and investigated by the unit manager. Quality issues were escalated to senior management as appropriate. Staff told us they often received feedback if they had completed an incident reporting form.
- Staff told us they received feedback in various ways. They described a supportive working relationship with their manager so could request feedback at any time but would also receive email communication as well as information during meetings. We saw information displayed by the manager on the noticeboard and from across the trust in the "chatterbox" newsletter.
- We saw minutes of ward meetings were available for staff to receive updated information and feedback.

Culture within the service

- We saw and staff told us that there was a strong commitment to providing a service that gave women a positive birth experience. They were proud of the 'home from home' set up of the unit and strived for women to be as comfortable as possible.
- Staff described a supportive working environment. They told us that they helped each other throughout difficult working times and there was a good occupational health system in place if additional support was required.
- Staff at the unit told us they were encouraged to incident report and promoted a positive safety culture.
- Staff told us they enjoyed their job and working for the trust. They said they felt valued by management and part of the team.

Public engagement

- We saw a poster informing women of the 'Maternity Engagement Group' which was a multi-agency meeting with a representative from the CCG, Healthwatch Shropshire, a supervisor of midwives, the HoM, the patient experience team and service users. We saw meeting minutes for September 2016 where patient experiences were shared and actions developed for areas of improvement.
- We saw forms for women to complete to provide feedback to staff working on the unit. Staff told us they encouraged these to be filled in so they could improve or receive recognition for when women had had a positive experience.

Staff engagement

- We saw a noticeboard was used to display lots of information about the maternity service and general information about the trust and upcoming events or changes to protocols.
- Monthly ward meetings ensured that the staff felt engaged and their views were heard. The staff told us they felt engaged and part of the trust especially with the rotation of midwives into the hospital. Staff told us they were comfortable to raise issues and concerns; they felt valued by the managers.
- Staff told us their ideas were taken on board and they felt very engaged with changes to the service and up to date with the progress of their suggestions.
- Staff at the unit had participated in the trust wide Midwifery survey, which had been used to gain views on how to move forward with the service.

Innovation, improvement and sustainability

- Four midwives working at the unit had recently completed a hypnobirthing training course to be able to support women who chose this option during labour.
- Staff told us there was an ongoing plan for the addition of another birth pool as this was very popular with women using the MLU.
- The unit was currently fundraising for active birth equipment to provide more options for women who wanted to deliver their baby at the MLU.
- The ongoing review of maternity services was considering the sustainability of all of the MLUs across the trust.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should ensure the unit safety dashboard is available and shared with staff.
- The trust should ensure all documentation is completed where women have been provided with advice on the telephone.