Shrewsbury and Telford Hospital NHS Trust

Bridgnorth Community Hospital

Quality Report

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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

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital service for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. 90% of the area covered by the trust is rural. There are two main locations, the Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. . The trust also provides a number of services at Ludlow, Bridgnorth and Oswestry Community Hospitals.

The midwifery led unit (MLU) at Bridgnorth had 75 deliveries in 2013/14 and 26 delivers for the year to date as at the end of August. The unit has two labour rooms, one with a pool and a five bedded bay for antenatal and postnatal care. There was a shared toilet for women during their stay. The MLU accepted women who had been assessed as low risk and suitable to deliver their baby there.

We carried out this comprehensive inspection because the trust had been flagged as a potential risk on CQC's Intelligent Monitoring system. The inspection took place between 14 and 16 October 2014 and an unannounced inspection on 27 October.

This maternity unit was rated as good although improvements in leadership were required.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The unit was visibly clean and well maintained. Infection control rates in the hospital were lower than those of other trusts.
- Patient's experiences of care were good.
- The trust had recently opened the new Shropshire Women's and Children's Centre at the Princess Royal site. This had seen all consultant-led maternity services and in-patient paediatrics move across from the Royal Shrewsbury site. We found that this had had a positive impact on those services.
- The service provided at the unit was well defined and escalation processes were in place.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Develop a clear strategy and vision for this service which aligns its current structure.

There were also areas of practice where the trust should take action which include:

- The trust should ensure that the quality dashboard reports accurately reflect performance against targets and that the thresholds are clear.
- The trust must ensure that all staff are consistently reporting incidents and that they receive feedback on all incidents raised so that service development and learning can take place.
- The trust must ensure that staff are able to access mandatory training in all areas

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 	We saw that the unit was well staffed and women were very satisfied with the care that they had received. The unit was fairly modern. It was comfortable and staff had access to all the necessary equipment. We were told that staffing levels were good although a clearly defined protocol for on-call arrangements was not in place. The staff we spoke with were unaware of a clear vision beyond the recent restructure. They felt supported by local management. Learning from incidents was not uniformly structured and staff reported that there was no generalised feedback.

Good

Bridgnorth Community Hospital

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Detailed findings

Background to Bridgnorth Community Hospital

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital service 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 & Wrekin. Life expectancy for both men and women is higher than the England average in Shropshire but lower in Telford and Wrekin.

The unit has two labour rooms, one with a pool and a five bedded bay for antenatal and postnatal care. There was a shared toilet for women during their stay. The MLU accepted women who had been assessed as low risk and suitable to deliver their baby there.

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this trust because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, the trust was considered to be a high-risk service.

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing and Patient Experience, Royal Surrey County Hospital NHS Trust

Team Leader: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team of 4 included one CQC inspector, a consultant obstetrician, a supervisor of midwives and an expert by experience.

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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the two local Healthwatch organisations.

We held two listening events, in Shrewsbury and Telford on 14 October 2014, when people shared their views and experiences of both hospitals. Some people who were unable to attend the listening events shared their experiences by email or telephone.

We carried out an announced inspection visit on 14–16 October 2014. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Shrewsbury and Telford Hospital NHS Trust.

Detailed findings

Facts and data about Bridgnorth Community Hospital

The midwifery led unit (MLU) at Bridgnorth had 75 deliveries in 2013/14 and 26 delivers for the year to date as at the end of August.

The unit has two labour rooms, one with a pool and a five-bedbay for antenatal and postnatal care. There was a shared toilet for women during their stay. The MLU accepted women who had been assessed as low risk and suitable to deliver their baby there.

Detailed findings

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	Good	Good	Good	Good	Good	Good

Notes

Maternity and gynaecology

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

Information about the service

The midwifery led unit (MLU) at Bridgenorth had 75 deliveries in 2013/14 and 26 delivers for the year to date as at the end of August.

The unit has two labour rooms, and a four-bed bay for antenatal and postnatal care. The MLU accepts women who have been assessed as low risk and suitable to deliver their baby there. Some women who booked and attend to deliver their baby in the MLU were transferred during labour if complications arose. The midwives are raising funds for a pool birth at the unit.

The MLU also cared for women who had delivered at the consultant led unit, now based at the Princess Royal Hospital (PRH) if they needed extra support (for example with breastfeeding).

We were told that there was one midwife on duty during the day and one women's service assistant (WSA). They were supported by a community midwife for 7.5 hours each day who would attend the unit as necessary. Outside of these hours there was one midwife on duty with support from a WSA; a second midwife worked on-call to support with deliveries as the need arose. The unit had a manager who worked office hours.

Outpatient visits were held daily for antenatal and postnatal women. A consultant clinic was held every other week and there was access to an ultrasound.

We inspected all operational areas of the MLU. We spoke with three members of staff and two patients and we reviewed two sets of notes.

Summary of findings

We saw that the unit was well staffed and women were very satisfied with the care that they had received. The unit was fairly modern, it was comfortable and staff had access to all the necessary equipment.

We were told that staffing levels were good although a clearly defined protocol for on-call arrangements was not in place.

The staff we spoke with were unaware of a clear vision beyond the recent restructure. They felt supported by local management. Learning from incidents was not uniformly structured and staff reported that there was no generalised feedback.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

We found that the maternity service in the midwifery-led unit (MLU) at Bridgenorth was good. We were told that staffing levels were good although a clearly defined protocol for on-call arrangements was not in place. The trust had a good system in place to report incidents. However, the staff we spoke with were not aware of any shared learning from incidents, with exception of one serious incident that had occurred at another unit 5 years previously.

Mandatory training had not been well attended for all courses and the report we were given did not include training data for courses specific to midwifery such as CTG training. We found that infection control arrangements were good and the unit appeared visibly clean on the day of our inspection.

Incidents

- Bridgenorth MLU reported a total of 25 incidents between July 2013 and July 2014.
- There was no analysis of trends in incidents for the MLU at Bridgenorth.
- There were no 'never events' reported by the trust. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented.
- We reviewed the root cause analysis (RCA) reports of four serious incidents from across all four MLUs. We saw that each RCA provided a detailed account of the event, the outcome and the root cause. Action plans were in place and included details of the person responsible, deadlines and confirmation that recommendations had been implemented.
- However, in one of the reports the actions did not address the issues identified. This particular report related to a stillbirth due to inaugural growth restriction (IUGR). It was identified that measurements had not been recorded and that this was an avoidable stillbirth. However, the learning documented did not address the points identified.
- It was also noted that this incident was recorded as 'low harm'. This had been investigated as a high-risk incident; however, we were told that, although high-risk incidents were investigated, they were not reported to the commissioners or local supervising authority (LSA). Incidents classified as serious were reported to the commissioners and LSA.
- We selected a random sample of incidents reported during the preceding 18 months. We noted that not all incidents had been categorised, and that some had been categorised as low when it would have been appropriate to categorise them as moderate or high. We requested an explanation from the trust but it was not provided.
- The staff we spoke with informed us that they would report an incident if it occurred. All staff had access to an IT-based system called Datix, with which to report incidents. They told us that regular reporting of incidents took place.
- The staff said they did not receive feedback on lessons learned from incidents unless they had been directly involved. Shared learning did not take place.
- We were aware of a serious incident that had occurred at another MLU at the trust 5 years before. We saw that changes had been made as a direct result of this incident and all the staff we spoke with were aware of the changes. It was noted that not all the issues identified during the incident had been fully addressed. For example, it had been identified that there had been an issue with checking and recording a baby's temperature. The documentation completed by staff had not been revised to include a specific prompt to record temperature, thereby placing reliance on the midwife to remember to do so.
- The women and children's directorate produced a quarterly newsletter that included information about lessons learned from incidents. The staff we spoke with did not mention this newsletter and we did not observe it on display in the unit.
- We were given the minutes of a perinatal mortality meeting. The minutes did not record the names of those present at the meeting. They documented a chronology of the event. However, we noted in one instance that, although the times were recorded, the date the incident occurred was not.
- We also noted that some minutes listed areas for discussion and considered things that could have been done differently, but this was not the case for all. For example, in one case, it was reported that a possible contributing factor to the baby's death was

pre-eclampsia. However, there was no consideration as to whether the mother's condition had been managed appropriately. We also noted another case in which it was reported that the mother's substance misuse could have been documented better, but the report did not state why or whether the mother had been referred for support with her substance misuse. In the cases where discussion had been provoked and learning points noted, there was no action plan recorded.

- The minutes we were given were essentially a summary of the chronology and potential cause for the event in each case. They did not report on actions required or consider trends in sub-optimal care.
- We were given a copy of the annual report of perinatal deaths for 2013/14. A total of 23 cases of foetal mortality (trust-wide) were reported during this period (two cases related to one set of twins). This study was carried out to identify the rate of stillbirths among Shropshire and Telford & Wrekin Primary Care Trust patients, and concluded that risk factors were age of the mother, weight of the mother, smoking status, ethnicity and multiple pregnancies. The report focused solely on risk factors and did not include a summary of RCA investigations or trends in sub-optimal care.

Cleanliness, infection control and hygiene

- We observed that Bridgenorth MLU appeared visibly clean and we saw staff regularly wash their hands and use hand gel. The hospital's bare below the elbow policy was also adhered to.
- There had been no reported cases of MRSA or MSSA bacteraemia for 2014/15, data provided was reported until end of July 2014.
- Data for hand hygiene, peripheral line care, decontamination and commode cleaning demonstrated positive results, although it was noted that the unit did not reported compliance with hand hygiene or the environmental checklist each month.

Environment and equipment

- The staff we spoke with told us that they had enough equipment; and that in the event of equipment being faulty, it was replaced or repaired promptly.
- We reviewed the resuscitation equipment and found that there was a small number of items that were out of date. We informed the manager who confirmed they would be replaced. However, checks had been performed by staff and this had not been identified.

Medicines

- The women we spoke with told us that they had received pain relief as needed.
- The staff we spoke with told us that there were no issues in obtaining pain relief or other medication required.
- We observed that medication was stored appropriately. We reviewed a sample, including controlled drugs, and found that the medication had been recorded as administered in accordance with requirements.

Records

- We observed that patient records were stored securely.
- The staff and women we spoke with informed us that all women were issued with a copy of their care plan which they retained and took to appointments throughout their pregnancy.
- We reviewed a sample of patient records and found that they had all been completed with relevant clinical information and signed and dated in accordance with guidelines.

Safeguarding

- The staff we spoke with told us they had attended safeguarding training. We reviewed the Statutory and Mandatory Compliance Report dated July 2014. We noted that training attendance at Level 3 child safeguarding for clinical services staff and midwives had been attended by 92% of midwives and 85% of other staff; training for adult safeguarding had been attended by 85% of midwives and 88% of all other staff.
- The staff we spoke with were able to describe with confidence the types of incidents or signs that would give them cause for concern about a child or vulnerable adult's welfare, and which may prompt a safeguarding concern.
- The trust had arrangements in place to report safeguarding concerns via an 'alert' or referral to social services. It is the line managers' responsibility to decide who makes a referral, as well as ensuring that other guidance is followed as set out in the trust's policy.
- The staff we spoke with told us that, if they were the first person to identify a concern, they would call the midwife safeguarding lead. If it was out of hours, they said they would call social services and follow this up with a faxed referral.

Mandatory training

- All staff were required to attend mandatory training. We were told that the mandatory training requirements had

been needs assessed and tailored to ensure professional updates and clinical skills were relevant to the staff member according to their speciality and location. For example, midwives working in the MLUs had additional life support training for neonates.
- We requested details of mandatory training attendance for maternity. We were provided with trust wide generic mandatory training attendance data as at July 2014. This did not include training data specific to maternity, for example, NLS or CTG training.
- The data provided showed that some mandatory training had been better attended than others. For example, hand hygiene had been attended by 55% of midwives and 67% of other staff, whilst attendance at infection prevention was low. Adult basic life support had been completed by 64% of all midwives and 67% of other staff, there was no data recorded for paediatric life support attendance.
- We noted in the quality and safety report 2014 that 70% of all midwives had completed new born life support training. However, data was not broken down at location level and there was therefore no assurance that midwives or other staff working at the unit had completed either paediatric life support or new born life support training.

Assessing and responding to patient risk

- There were specific care pathways for women who used the maternity or gynaecology services in accordance with their clinical and social needs. We reviewed a sample of these and found that they were followed in practice.
- We saw that appropriate records were maintained and the department used early warning scores to monitor any potential deterioration in a woman's condition.
- We talked to midwives and WSAs about providing life support to a mother or newborn baby. All of the staff we spoke with described confidently how they would perform resuscitation.

Midwifery staffing

- We were told that there was one midwife on duty during the day and one WSA. They were supported by a community midwife for 7.5 hours each day who would attend the unit as necessary. Outside these hours, there was one midwife on duty with support from a WSA; a second midwife worked on call to support with deliveries as the need arose. The unit had a manager who worked office hours.
- The maternity department did not use agency midwives, and that cover was always sourced internally through extra shifts for permanent staff or by using bank staff.
- The staff we spoke with told us that some days could be busy, but workloads were manageable and they always managed to get a break.
- During the night shift, on-call cover was provided by a second midwife. The distance each midwife lived away from the unit varied, but calls were made in sufficient time should a second midwife be required.
- We were told that, if the midwife on call lived more than 30 minutes away, a second midwife who lived fewer than 30 minutes away would also be on call. The MLU had agreed this procedure locally; however, there was no trust-wide directive for this process. As part of the serious incident 5 years before, it was identified that one of the factors related to the distance the on-call midwife was based away from the MLU the on-call midwife was based. However, the trust had not formalised arrangements for on-call duties within MLUs.
- We were told that all women received one-to-one care in labour and there were always two midwives present at delivery.

Escalation policy

- The trust had an escalation policy that outlined optimal level and sub-optimal staffing levels, this was due for review in November 2014. There was an appendix describing conditions where the escalation procedure might need to be followed.
- The staff we spoke with told us that management always tried to have the agreed number of staff on shift whenever possible but that this did not always happen.
- We were told that Bridgenorth MLU would only 'close it's doors' if the consultant led unit was in need of additional staff.

Are maternity and gynaecology services effective?

Good

The maternity services were effective. We noted that there were arrangements in place to audit the care and services provided, although the purpose of audits and

implementation of recommendations could be improved. We saw that women received pain relief as required and adequate there were arrangements were to ensure that women and their babies received nutrition and hydration.

Overall outcomes for women were good, although some outcomes were not consistently achieved and the data reported was not always accurately colour coded. Data was also not reported by location which meant that it was not possible to observe performance at a particular site; this could 'skew' the data at location level.

Evidence-based care and treatment

- The trust had an 'assurance midwife' who was responsible for ensuring that all new standards and published guidelines were reviewed and implemented. We were told that all new National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (ROCG) guidance was reviewed by the assurance midwife and benchmarked against the trust's current arrangements. A report was prepared for the governance committee detailing the differences between the new guidance and current trust standards. We were told that discussions were held to decide whether change was necessary.
- We reviewed care pathways and patient records and from the samples we reviewed found them to be compliant with the associated standards and local procedures, however we noted that the temperature for one baby had not been recorded.
- The staff we spoke with told us that they regularly received updates regarding changes to guidelines and that these were also available on the intranet.
- A women and children's clinical audit plan was prepared annually; audits were completed by medical staff throughout the year. We reviewed the plan, which included local and national priorities. We saw from our review that the audits were of relevance and progress had been made with the plan; however, we noted that some of the audits had not been started, and others started but not completed in line with the timescales set at the beginning of the year.
- The trust had an audit midwife responsible for overseeing assurance audits that were undertaken by midwifery staff and separate to the clinical audit process. We were told that a review of both the clinical and assurance audit plans was undertaken to ensure there was no duplication. The assurance plan included re-audits of the 52 Clinical Negligence Scheme for Trusts (CNST) standards.
- We reviewed a sample of assurance audits and saw that they clearly stated their aims, objectives and findings. One of the audits, a re-audit 'Audit of care of women in labour', reported a small decrease in performance of staff in three individual aspects of maternal observation in second-stage labour. The recommendation was to address this with individual staff. However, there was no evidence that the report's findings were shared with all staff to ensure generalised learning. Findings had not been reported by location.
- The trust had an audit midwife responsible for overseeing assurance audits which were undertaken by midwifery staff and separate to the clinical audit process. We were told that a review of both audit plans is undertaken to ensure there is no duplication. The assurance plan includes re-audits of the 52 CNST standards.
- We reviewed a sample of assurance audits and saw that they clearly stated their aims, objectives and findings. One of the audits, a re-audit audit of care of women in labour reported a small decrease in performance of staff in three individual aspects of maternal observations in second stage labour. The recommendation was to address this with individual staff; however, there was no evidence that the report findings were shared with all staff to ensure generalised learning. Findings had not been reported by location.

Pain relief

- All the women we spoke with all told us that they had received appropriate pain relief.
- The staff we spoke with informed us that there were never any issues in providing the required pain relief for women and that this was done in accordance with their wishes and clinical need.

Nutrition and hydration

- The women we spoke with were satisfied that they had received adequate meals and hydration.
- We noted that the unit did not have facilities to support women to make up their baby's bottle feed, if choosing to feed their baby on formula milk. Mothers were expected to bring in a 'ready made' formula, but there was some 'ready made' formula available for new

mothers if they had not brought their own. This meant mothers were not receiving direct support and advice and were expected to buy their own baby milk before coming to hospital.

Patient outcomes

- The maternity department maintained a 'quality and performance dashboard' that reported on activity and clinical outcomes. Data was reported at a trust-wide level and by clinical commissioning group (i.e., whichever authority funded a woman's care). Activity by location was reported but performance was not; therefore, it was not possible to review and report on data by location.
- The total number of deliveries at Bridgenorth was 75 for 2013/14 and 26 for the year to date as at end of August 2014.
- Overall, clinical performance was equal to or above expected performance, with the occasional exception by month. For example, we noted that the rates of third- and fourth-degree tears for first-time mothers was higher than expected for July 2014.
- The dashboard used a traffic-light rating system to describe performance against a range of targets. It was unclear what the threshold was for performance against each target on the report. This meant that the data could not be relied in in its current format.
- We also noted that, although the dashboard provided activity by location, performance data was not reported separately. It was therefore not possible to distinguish between the care provided at each MLU.
- One-to-one care in labour was reported at 87.3% for the year to date (until end August) for Shropshire, and Telford and Wrekin. The staff we spoke with told us they were able to give all women one-to-one care during established labour.
- The dashboard did not report on maternity readmission rates, unexpected admissions to the neonatal intensive care unit or unexpected maternal admissions to the intensive care unit, one-to-one care in labour or the ratio of midwives to births. It also did not report on the transfer rate of women from MLUs to the consultant-led service. All this would be helpful to review at a glance, to ensure that the service is fully monitored each month.
- We requested data on the transfer rate of women being transferred from MLUs to the consultant-led service. We were only given percentages of women who had delivered their baby at the consultant-led unit instead of their intended unit. Data was broken down by the stage of pregnancy at which they changed their mind or a clinical decision was made. The reasons were also reported; however, it was not entirely clear for all categories whether this was during labour.
- Access to maternity services was consistently below the 90% target for the percentage of bookings with a gestation of fewer than 12 weeks, and below the 75% target for the percentage of women with access to the same midwife throughout their pregnancy.

Competent staff

- All the staff we spoke with told us that they had received their annual appraisal and supervision and had found this process helpful. We saw that trust wide data reported 97% of staff had completed their appraisal by August 2014.
- To ensure that all midwives had their competencies maintained up to date, the trust had reviewed and revised its 'rotation' arrangements for midwives. Previously, a proportion of midwives rotated from each of the four MLUs to the consultant led-unit to update their skills. Each rotation lasted 1 year. This arrangement had been in place for over 30 years. Before then, there had been no consistency in the selection process and therefore not all midwives rotated.
- We were told that, to improve this process, the trust had recently developed a database of all midwives to review when they had last 'rotated'. From 2015, there will be two rotations each year for a period of 3 months each. Rotations will be structured to ensure all midwives complete a rotation.
- All members of staff were required to complete mandatory and statutory training. We were told that mandatory training had been needs assessed according the person's location and job role. For example, all midwives were expected to complete CTG training and midwives at the MLUs were expected to complete neonatal life support training.

Multidisciplinary working

- The staff we spoke with reported good multi-disciplinary working both internally and externally.
- We were told that external arrangements also worked well. There was good communication and links with

local GPs as well as social services. Information was regularly received from social services, specifying any support that an individual may be receiving or may need.

Seven-day services

- Out-of-hours services were available in emergencies. All women could report to the main hospital in an emergency either via the accident and emergency (A&E) department or the maternity unit reception. The MLU had scanners available that could be used out of hours if necessary. During the day, the hospital's early pregnancy assessment unit or day assessment unit were available. Guidance on self-referral or GP referral was provided at a woman's first appointment.
- We were told that, if needed, the pharmacy service was available out of hours using the on-call system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had set procedures for assessing a person capacity whether they arrived at the hospital via the emergency or elective route

Are maternity and gynaecology services caring?

Good

Women who attended the Bridgnorth MLU received good care. The women we spoke with told us that staff were very caring and that information had been explained to them about their treatment.

Compassionate care

- The women we spoke with reported that they received a good standard of care from all members of staff.
- Feedback from the CQC Maternity Patient Experience Survey showed positive findings overall for each aspect of maternity care provided by the trust.
- We requested data on the NHS Friends and Family Test results, although this was not provided for maternity.

Understanding and involvement of patients and those close to them

- The women we spoke with reported that communication was good throughout their pregnancy and that their partners had been involved.

Emotional support

- The trust had a bereavement midwife who worked at the Princess Royal Hospital (PRH) and was responsible for speaking with women and their families who were bereaved during or after childbirth or needed a termination for medical reasons. The midwife offered support and advice to women and their families at specific stages, but was also contactable if needed. Information about various agencies that provide counselling support for women and their families was also provided.
- Women who suffered a miscarriage or bereavement during their pregnancy, or who needed a termination for medical reasons, were all referred to the PRH for their care and treatment.

Are maternity and gynaecology services responsive?

Good

Maternity services were responsive. We found that planning and delivery were good and access arrangements worked well. In, general people's individual needs were met.

Service planning and delivery to meet the needs of local people

- We asked for a copy of the directorate's business plan but this was not provided. We were told by staff that they were able to meet the needs of local people. It was unclear how this had been assessed as part of a forward planning exercise.

Access and flow

- We were told by staff that there were no concerns about the access and flow of patients. The number of deliveries a month averaged five and the unit could always accommodate women who needed extra support for their postnatal care if they had delivered their baby at the PRH.
- The trust had a set target of 90% for women making a booking with a gestation of fewer than 12 weeks and 6 days. This was being met for most months, except for teenage pregnancies where performance varied between 69% and 86%.

Maternity and gynaecology

Meeting people's individual needs

- We were told that women who used the service and were unable to speak English fluently could access an interpreter service if needed. An interpreter could be booked to attend antenatal appointments, and a telephone service was also available. Staff reported that this worked well.
- We were told that information leaflets were available in other languages. These were produced by the Department of Health, accessible to staff via the intranet and could be printed for women as needed.
- The staff told us that, if a patient who used the service had any specific needs (whether mental health, social needs or safeguarding), they would contact the trust safeguarding lead or refer to guidance on the intranet for advice.
- We were also told that there was a multidisciplinary meeting held monthly to discuss midwifery patients with extra support needs to ensure that their individual care plan was suitable.
- We noted that the unit did not have an area for women to make formula milk for their babies.

Learning from complaints and concerns

- We observed that a Patient Advice and Liaison Service (PALS) leaflet was available for women who wanted advice and support. We asked whether there was a complaints leaflet and were told that there no longer was a trust complaints leaflet for patients but it had been replaced by a PALS leaflet. This meant that patients may not feel able to make a formal complaint.
- We reviewed a summary of complaints made between August 2013 and July 2014. No complaints about Bridgenorth had been received during this period.

Are maternity and gynaecology services well-led?

Good

There was a governance structure in place and arrangements for patients to provide feedback. Staff felt well supported by their immediate line manager but felt supported by senior management could be improved. The directorate had recently accomplished a major restructure of the service, moving obstetric led services to a new unit based at the Telford site. The vision for the next steps for maternity services was not yet clear.

We saw some positive examples of good governance, but we noted that reporting of data was unclear and could potentially be misleading, and minutes of discussions about performance could be improved.

Vision and strategy for this service

- We asked for a copy of the directorate's business plan. However, we were not provided with one.
- A maternity services review was commissioned by the two local clinical commissioning groups. The review focused on patient safety, quality of care, sustainability of workforce numbers, educational needs, reporting of serious incidents and patient complaints. It also looked at sustainability of the "hub and spoke model". This is where a single Consultant Unit (the 'Hub') provides expert care for complex pregnancies and offers support and advice for midwives and GPs caring for women at home or in the MLUs (the spokes). It also considered the areas highlighted by the coroner following the inquest into the death of a new born baby within the county. Opinions of mothers who had received care, and their partners and family members, were also sought. The review identified areas for development and implementation. It was approved in April 2014 and we saw that progress had been made with its implementation.

Governance, risk management and quality measurement

- There were clearly defined committee arrangements in place. The directorate held a care group centre board (CGCB) that was attended by senior management and medical staff within the division as well as other key individuals. Sub-committees that reported to the CGCB included a maternity governance group and a gynaecology governance group. The CGCB reported to the risk management executive committee, a direct sub-committee of the trust board.
- The CGCB received reports on human resources and staffing issues as well as performance data for each division. We reviewed the minutes for August and September 2014 and noted that discussions around performance were mainly about targets that had been met, or general information about what the targets

were. There was little discussion recorded about targets that had not been met. We noted that in August a 'Quality and safety report' was presented. The report said, 'it was highlighted that there appeared to be a lot of red on the dashboard. Target levels and the 0% figures were discussed.' However, there was no record in the minutes about which targets were red or whether they related to maternity or paediatrics.

- We noted in reviewing the dashboard that, although some areas were coloured red, amber or green, it was not clear what the threshold was for each. A local or national target was recorded (for example, for access to maternity services); there was a target of 90% for the percentage of bookings with a gestation of fewer than 12 weeks 6 days. We saw that the same percentage achievement for one month was coloured red and for other months amber. . It was unclear what the threshold was for performance to be coloured amber.
- Closer scrutiny of the dashboard showed that some performance had been incorrectly coloured and appeared to demonstrate a positive result because it had been coloured green when, in fact, the figure reported indicated otherwise. There were a number of outcomes that had been incorrectly coloured green. For example, the target for the 'overall normal birth rate' was set at 70% for 2 of the 5 months reported on; the outcome achieved was less than 70%, but it was coloured green. This was the same for assisted birth rates. Forceps rates were also incorrectly coloured green for all 5 months. Induction rates were higher than expected each month but had been coloured green for 4 of the 5 months. This meant that, 'at a glance', the data reported could not be relied upon.
- The dashboard did not report on maternity readmission rates, unexpected admissions to neonatal unit or unexpected maternal admissions to the intensive care unit, one-to-one care in labour or the ratio of midwives to births. It also did not report on the transfer rate of women from MLU to the consultant-led service. All this would be helpful to review at a glance, to ensure that the service is fully monitored each month.
- It was noted that the patient safety report was discussed at the maternity governance meeting each quarter and that this did include unexpected admissions to the NNU.
- The dashboard did not report performance for individual units.
- The divisional governance committees received regular reports on, for example, performance, patient experience, serious incidents, complaints, audits, risk register updates and infection control, and we saw evidence of this in the minutes.
- There was a risk management executive committee, a direct sub-committee of the trust board.
- A joint maternity and gynaecology feedback group for wider learning was also held every 4 weeks. Band 7 nurses and midwives fed into the governance groups. Each ward and department had its own individual team meeting each month.
- Each division maintained its own risk register and there was a strategy in place outlining how this should be updated and monitored. We reviewed the risk registers and saw that they had a clearly defined title, description and owner; each risk had been scored and existing controls recorded along with any action needed.
- The staff we spoke with told us that there were monthly team meetings that they could attend, which included discussion around general issues affecting their ward. However, most of the staff we spoke with were unaware of how their department was performing against key targets, and they told us that they did not receive feedback on lessons learned from incidents unless they had been directly involved.

Leadership of service

- The directorate had a clearly defined accountability structure. The care group director (also the head of midwifery) had responsibility for overseeing midwifery and nursing staff, and the deputy head of midwifery and care group lead nurse, business manager and fertility manager all reported directly to the care group director. Although reporting arrangements for line management below this were not documented, staff were aware of their immediate reporting lines.
- The care group medical director was directly accountable for the clinical directors for gynaecology and maternity. As above, staff were aware of reporting lines below this but these had not been documented.
- All the staff we spoke with reported that they felt very supported by their immediate line management and that they had good working relationships with all staff groups.
- The staff we spoke with told us they felt confident in following the trust's whistleblowing policy if they needed to.

Maternity and gynaecology

Public and staff engagement

- The women and children's care group had implemented a patient experience and engagement strategy in September 2014. The strategy had been shaped by various media, including complaints, focus groups, surveys and incidents.
- We saw that the care group had arrangements for women to complete the NHS Friends and Family Test, although the response rate was below the trust target.
- The annual staff survey reported that staff were dissatisfied with the level of communication between senior management and staff, and that they did not consider incident reporting to be fair and effective.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Develop a clear strategy and vision for this service which aligns its current structure.

Action the hospital SHOULD take to improve

- The trust must ensure that all staff are consistently reporting incidents and that they receive feedback on all incidents raised so that service development and learning can take place.
- The trust must ensure that staff are able to access mandatory training in all areas
- The trust should ensure that the quality dashboard reports accurately reflect performance against targets and that the thresholds are clear.