Somerset NHS Foundation Trust

Bridgwater Community Hospital

Inspection report

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Bridgwater
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Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	**Insufficient evidence to rate**
Are services well-led?	**Insufficient evidence to rate**

Our findings

Overall summary of services at Bridgwater Community Hospital

Insufficient evidence to rate

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

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

The Mary Stanley midwife-led unit at Bridgwater Community Hospital provides maternity services to the population of Bridgewater, Minehead, Glastonbury and the surrounding areas.

Maternity services include a midwifery-led birthing centre with 2 birthing rooms both with birthing pool rooms. At the time of inspection, one birthing room was used as a clinic room and the other was set up for births. Between October 2022 and October 2023, 5 babies were born at the Mary Stanley midwife-led unit at Bridgwater Community Hospital.

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

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

We had not previously rated this hospital. We did not have sufficient evidence to rate the hospital overall. We rated maternity services requires improvement in safe and well-led.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Musgrove Park Hospital - https://www.cqc.org.uk/location/RH5A8
- Yeovil District Hospital - https://www.cqc.org.uk/location/RH5O4

How we carried out the inspection

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

We visited the two birthing rooms at Mary Stanley midwife-led unit.

We spoke with 2 midwives.

We reviewed 2 patient care records and 2 observation and escalation charts.

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

Our findings

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

Maternity

Requires Improvement

We rated it as requires improvement because:

- The service had high rates of staff sickness. Staffing levels impacted on the sustainability of the birth centre service which had been suspended between February and July 2023.
- Equipment was not always maintained safely.
- Leaders did not monitor waiting times to ensure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.
- There were ineffective processes for learning from incidents.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.
- The birth centre did not have a specific vision or strategy.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.

Is the service safe?

Requires Improvement

We had not previously rated this service. We rated it as requires improvement.

Mandatory training

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

Staff completed professional obstetric multidisciplinary training (PrOMPT) training once a year. The service made sure that staff received multi-professional simulated obstetric emergency training. As of 22 November 2023, 93% of midwives and 91% of midwifery support workers who worked at Musgrove Park Hospital or Bridgwater Community Hospital had completed yearly PrOMPT training.

The mandatory training was comprehensive and met the needs of woman and birthing people and staff. Training included skills and drills training and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for woman and birthing people and babies. Training data for staff who worked at Mary Stanley Birth Centre was not separated from staff at Musgrove Park Hospital as community midwives worked across the two sites.

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

Maternity

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Across maternity services at the trust 80% of staff had completed level 3 safeguarding training as of 20 November 2023.

Community staff had access to regular safeguarding supervision. The birth centre lead offered safeguarding supervision sessions every month. Staff had to attend 4 supervision sessions a year and this was monitored by the safeguarding team.

Cleanliness, infection control and hygiene

The service did not always control infection risk effectively.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits showed between April and October 2023 the Mary Stanley Unit consistently scored above 98% in cleaning monthly audits. However, in room 1 we found thick dust under the bed and at the bottom of a machine to assess vital signs. We raised this with the birth centre lead at the end of inspection.

Leaders did not complete regular hand hygiene audits at the Mary Stanley midwife led unit. Data showed hand hygiene audits were completed every month in all other maternity areas within the trust.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. We saw staff recorded on checklists that water outlets were flushed three times to reduce risk of legionella.

The birth centre manager was aware of processes for managing and controlling the risk of legionella including regular flushing of taps on the birth centre. We saw that staff completed checklists to confirm taps were flushed 3 times a week.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used ‘I am clean’ stickers to show equipment was clean and ready for use.

Environment and equipment

Maintenance of equipment did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

Electrical equipment was not properly maintained. Several items of equipment were out of date for electrical safety testing. For example, an examination lamp in birthing room 1 was due electrical safety testing in July 2022. We reviewed compliance for equipment testing at the Mary Stanley unit and this was 30.6%. We raised this with the birth centre lead following the inspection and they told us electrical safety testing would be completed as soon as possible.

Staff did not have immediate access to a defibrillator for adult resuscitation on the birth centre. The community matron had recorded this as a risk on the maternity risk register since March 2023. Staff had access to adult resuscitation equipment and a defibrillator that was stored on the adjacent ward that provided medical care and rehabilitation to older adults. The trust updated the risk assessment following the inspection.

Maternity

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

Staff carried out daily safety checks of specialist equipment. Records showed the neonatal resuscitaire was checked daily.

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

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there was access to a hoist noodle-shaped floats for pool evacuation.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Assessing and responding to risk

Key information was not always shared effectively when care was handed over to other healthcare professionals. However, staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. An incident occurred in August 2023 when midwife to midwife handover did not occur when a woman was transferred from the Mary Stanley birth unit to the Bracken Birth Centre at the main hospital site by ambulance. A midwife did not travel in the ambulance to supervise the transfer and did not call the main hospital site to handover the care. This was not in line with the trust policy and there was a risk of the woman deteriorating in transit without access to a midwife.

Leaders did not monitor waiting times to ensure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 2 MEOWS records and found staff correctly completed them. However, managers did not audit use of MEOWS at Mary Stanley midwife-led unit and could therefore not be assured that deterioration of women and birthing people was escalated and acted upon in a timely manner.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed the criteria for use of the birth centre and found they were in line with national guidance. We reviewed 2 records which showed staff risk assessed women and birthing people at each antenatal appointment and ensured criteria for use of the birth centre were met. However, the service did not complete audits on this.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The service had not completed a ligature risk assessment of the unit.

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

Maternity

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk.

High levels of staff sickness and staff vacancies impacted on the sustainability of the birth centre service. The home birth service and births at the Mary Stanley Birth Centre were suspended for over 4 months from February 2023 to the end of July 2023. The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

Managers moved staff according to the number of woman and birthing people in clinical areas. The maternity escalation plan had 4 alert levels: green – normal working, amber – persistent excess pressure, red – severe and prolonged excess pressure, and black – unit closed to admissions and patients diverted to neighbouring trusts. Community midwives were part of the escalation plan and would support on Bracken Birth Centre the alongside midwifery unit at Musgrove Park Hospital when needed. If the escalation alert level was anything other than green the homebirth service would be reduced, and the provision intrapartum care (during labour) would be suspended at Mary Stanley midwife-led birth centre as staff would be redeployed to maternity services at the main hospital site. The Mary Stanely midwife-led unit was closed to births for five months between February 2023 and July 2023 when it re-opened to births. During the planned closure two women had booked to birth at the Mary Stanley unit and these women were offered to birth at the alongside midwifery led unit Bracken birth centre instead.

The birth centre was staffed by community midwifery staff. Two midwives needed to be available to facilitate a birth at the birth centre. The availability of community midwifery staff impacted on the sustainability of the Mary Stanley midwife-led unit. The birth centre lead midwife or community matron adjusted staffing levels daily according to the needs of woman and birthing people. Band 7 midwives met every week to discuss staffing across the maternity service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended the service needed 40.06 whole-time equivalent (WTE) midwives Band 4 to 8 to run community services including home births and births at Mary Stanley birth centre. As reported in the October 2023 maternity and neonatal governance report, the trust had an 8% vacancy rate for community midwives (4.4 WTE midwives) required.

Compliance with annual appraisals was below the trust target.

Managers supported staff to develop through appraisals of their work however, data showed not all community midwifery staff received an appraisal yearly. The compliance rate with completion of appraisals for community midwifery staff was 58.6% as of November 2023 against a trust target of 92%.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used electronic records. We reviewed 2 records and found they were clear and complete.

The service did not complete documentation audits at the time of inspection.

Maternity

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

Records were stored securely. Staff locked computers when not in use.

Medicines

There was a risk medicines were not always stored under the correct conditions. The service used systems and processes to safely prescribe, administer and record.

Safety of storage of medicines could be improved. At the time of inspection staff did not monitor and record fridge temperatures. Staff stored medicines in a locked fridge in the staff office that could only be accessed by authorised staff. Medicines we checked were in date and stored at the correct temperature. However, due to the lack of monitoring there was a risk medicines were not stored under the correct conditions.

Staff had access to emergency medicines boxes in both birthing rooms to support management of post-partum haemorrhage and cord prolapse. The items in all four boxes checked were in date for use.

No controlled drugs were stored on the Mary Stanley unit. For pain relief women and birthing people had access to birth pools and oral over the counter painkillers only. Women and birthing people requesting high levels of pain relief, for example an epidural, would be transferred to the obstetric unit at Musgrove Park Hospital.

Incidents

Processes for learning from incidents were ineffective.

The birth centre lead was not aware of any incidents that had occurred at the Mary Stanley Standalone Birth Centre in the past year.

Following the inspection, we requested the incidents that had occurred at Mary Stanley Birth Centre in the past year. One clinical incident occurred in August 2023 when a woman was transferred to the Bracken Birth Centre alongside midwifery-led unit.

The transfer was not managed in line with the trust guidance on 'criteria for transfer to labour ward from the birth centres (maternity)' as in this incident the woman was not accompanied by a midwife in the ambulance and there was no midwife-to-midwife handover either in person or by phone. The woman was transferred from Mary Stanley unit to the Bracken Birth Centre at Musgrove Park Hospital. This was also not in line with the trust guidance which only outlined processes for transfer to the labour ward at Musgrove Park Hospital. It was not clear from the incident report if the trust guidance had been followed in terms of ensuring the labour ward co-ordinator was informed of the transfer or if an obstetrician was informed of the transfer within 15 minutes of the woman's arrival.

Is the service well-led?

Requires Improvement

We had not previously rated this service. We rated it as requires improvement.

Maternity

Leadership

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for woman and birthing people and staff. However, executive leaders did not always understand and manage the priorities and issues the service faced.

Maternity services at the trust came under a service group for children, young people and families. This included services such as child and adolescent mental health services (CAMHS), women's sexual health and maternity services.

The maternity leadership team for the trust was formed as part of the trust merger in April 2023. The structure of the senior leadership team did not support effective clinical oversight of maternity services. The service group had quadrumvirate that consisted of the director of midwifery (DOM), the associate medical director for obstetricians and gynaecology, sexual health and dental, who was a vascular surgeon by background and the associate director of patient care for the service group. There was not a dedicated triumvirate for maternity services.

Maternity board level safety champions were not effective in their role in improving 'floor to board' communication. We reviewed 5 notes and actions from maternity board level safety champion meetings. These meetings were in May 2023, July 2023, August 2023, September 2023 and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. As part of the inspection, we spoke with the 3 board level safety Champions.

Mary Stanley midwife led unit at Bridgwater Hospital was managed by a Band 7 birth centre lead who was supported by a Band 8 community matron who was based in the community.

Local leaders were visible and approachable in the service for woman and birthing people and staff. Leaders were well respected, approachable, and supportive. The chief nurse, director of midwifery and deputy director of midwifery had visited the birth centre.

Vision and Strategy

There was no clear vision for the Mary Stanley midwife-led unit at Bridgwater Community Hospital.

There was a vision and strategy for the trust maternity and neonatal services 2023 – 2027. The priorities included: personalised care, quality & safety, improving health, wellbeing, and our future. However, the Mary Stanley midwife led unit was not specifically included in this strategy and staff were not aware of the vision for the unit.

Culture

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

Staff we spoke with were positive about working at the trust.

The service had received no complaints in relation to Mary Stanley Birth Centre in the past year.

Governance

Leaders did not operate effective governance processes to ensure oversight of the birth centre.

Maternity

The trust had poor oversight of activity levels at Mary Stanley birth unit. The community matron and birth centre lead were unable to tell us how many births there had been at the standalone midwifery-led unit in the past year. We requested this information following the inspection and the trust told us 3 babies had been born between December 2022 and November 2023 at the Mary Stanley Birth Centre. The figures provided did not match up with the number reported on the trust maternity dashboard. For example, the trust told us one baby had been born at the Mary Stanley Birth Centre in August 2023, but the maternity dashboard reported 0 babies were born at the standalone midwifery led unit in August 2023. Similarly the trust told us 0 babies were born at the Mary Stanley unit in March 2023 and the unit was closed, but the maternity dashboard reported 1 baby was born at the standalone midwifery led unit in March 2023.

The trust did not have effective oversight of whether the Mary Stanley unit was open or closed to births. The birth centre lead told us if a birth could not be facilitated at Mary Stanley unit due to staffing levels, this would be reported as an incident. However, the service did not monitor how many births were facilitated at the alongside midwifery-led unit at Musgrove Park Hospital when people's choice to use the Mary Stanley Birth Centre could not be met.

Managers did not formally audit transfers out of the standalone midwifery led birth centre to the main hospital site. We requested transfer audits for the past year and the service provided details of one transfer that had occurred in the past year out of 3 births. We were not confident the service had oversight of all transfers as the information provided by the trust did not include the transfer during labour of a woman whose record we reviewed during the inspection.

The service also did not audit whether the criteria for use of the birthing centre were met at the time of labour. This was not in line with the trust's policy, 'criteria for transfer to labour ward from the birth centres (Maternity) version 2 which was due for review in May 2023. This stated all transfers from the birth centres to the obstetric units needed to be incident reported.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. For example, the guidance on 'criteria for transfer to labour ward from the birth centres (maternity)' was six months out of date at the time of inspection and was due for review in May 2023.

The birth centre lead met with other band 7 senior midwives every week to discuss safety and performance.

Management of risk, issues, and performance

There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service is monitored and processes to learn from incidents were not effective.

There were significant failures in audit systems and processes. The service had not audited the use of Modified Early Obstetric warning score (MEOWS), handover tool Situation Background Assessment (SBAR), or the electronic records system.

There was one recorded risk in relation to Mary Stanley Birth Centre on the maternity risk register. The recorded risk was in relation to the lack of a defibrillator on the birth centre. There were no recorded mitigations to this risk, but it was observed on inspection that staff had access to the defibrillator on the adjacent ward.

Maternity

Risks were not always effectively mitigated. For example, there was a recorded risk in relation to transferring women and birthing people to the main hospital from the Mary Stanley Birth Centre to the main hospital site which had been a recorded risk since March 2021. The risk of delayed transfer was not monitored or mitigated effectively as the service did not regularly review capacity and demand in the ambulance service and the impact this may have on the safety of the homebirth and standalone midwifery led unit service.

Managers monitored risk across maternity services on the maternity services risk register. Top risks across maternity services were safe midwifery staffing, and shortages of sonography (ultrasound scanning) staff. These risks were mitigated by ongoing midwifery recruitment and seeking further funding for sonography staffing.

The service did not effectively audit clinical outcomes for women and birthing people who delivered their babies at the standalone birth centre. The maternity dashboard did not include any clinical outcomes data in relation to the Mary Stanley standalone birth centre at Bridgwater Community Hospital.

Information Management

Staff could find the data they needed. The information systems were integrated and secure.

The information systems were integrated and secure**.** The service used an electronic record system.

Engagement

There was a limited approach to engaging with people who used the service.

The service encouraged but received limited feedback from women, birthing people, and families. No complaints were received about the Mary Stanley Birth Centre in the past year.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP visited Mary Stanley birth centre in July 2023 and made recommendations including making the environment more calming, updating noticeboards and putting up information on active birth positions.

Learning, continuous improvement and innovation

There was limited evidence of quality improvement and innovation.

Areas for improvement

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

Action the service MUST take to improve:

Maternity

- The service must ensure where responsibility for the care and treatment of women and birthing people is transferred to timely sharing of information and care planning takes place . Regulation 12 (2) (i)
- The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e)

Maternity

- The service must ensure there are effective processes for learning from incidents. Regulation 17 (1) (2) (a)
- The service must ensure there are effective processes for amending the homebirth and midwifery-led unit provision at times of increased demand on ambulance services to ensure timely transfer to the obstetric-led maternity unit is not delayed. Regulation 17 (1) (2) (a)
- The service must ensure there are governance systems to consistently monitor the effectiveness of the service including local audits and processes to learn from incidents. Regulation 17 (2) (a) (b) (e))
- The service should ensure all midwifery staff receive a yearly appraisal. Regulation 18 (2) (a)

Action the service SHOULD take to improve:

- The service should ensure clinical outcomes data in relation to the the Mary Stanley free standing birth unit at Bridgwater Community Hospital is included in the maternity dashboard.
- The service should ensure medicines are stored at the correct temperature.

Our inspection team

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