Shrewsbury and Telford Hospital NHS Trust

Ludlow Midwife Led Unit

Quality Report

Gravel Hill
Ludlow
Shropshire
SY8 1QX
Tel: 01743 261000
Website: www.sath.nhs.uk

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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	Requires improvement
Maternity and gynaecology	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Ludlow Midwife Led Unit (MLU) is based within Ludlow Community Hospital which is run by Shropshire Community Healthcare NHS Trust. Maternity services are provided by Shrewsbury and Telford Hospital NHS Trust. The MLU provided a midwifery service for low risk women 24 hours a day. The MLU team also provided community midwifery services to women in the Ludlow and surrounding area.

This unannounced inspection on 3 January 2017 was part of the focused, follow-up inspection of the trust which, included all maternity services.

Ludlow MLU closed on 13 October 2016, due to the poor and unsafe condition of the premises. Alternative accommodation within Ludlow Community Hospital was identified and the MLU relocated and reopened on 7 November 2016.

We rated Ludlow Midwife Led unit as requires improvement overall.

- Ludlow MLU did not fully reflect a "home from home" environment to provide a service focused on the needs of low risk woman. The environment was in poor condition, some equipment was not clean or dust free. The lack of an immersion bath meant that women could not receive low-level pain relief.
- Midwifery staffing arrangements meant that continuity of care during the women's pregnancy by their named midwife was not possible.
- Patient records did not include all required information such as all medicines administered during labour and all patients' observations.
- Not all records of medicine administration were up to date and accurate and the temperature of the room where medicines were stored was not monitored.
- There was a lack of challenge by staff to ensure that the environment and equipment promoted the home from home of a midwife led unit.
- The review of maternity services and the future of Ludlow MLU was of concern to staff.

However:

- Ludlow Midwife Led unit provided opportunities for low risk women in Ludlow and the surrounding areas who wanted to have their baby in a midwife led unit.
- Staff were caring and compassionate.
- The Supporting Women with Additional Needs team provided support to both patients and midwives for the care and support of vulnerable women.
- No serious incidents had been reported between 01 November 2015 and 31 October 2016.
- Care and treatment is delivered in line the current evidence based guidelines. Staff adhered to the trust Intrapartum Care on a MLU or Homebirth policy (June 2016), all trust wide policies and procedures were available to staff on the intranet.
- Effective systems of communication were established between the consultant led unit and the MLU, GPs and other health professionals ensuring that effective care and treatment was delivered.
- A full review of the maternity service was ongoing across all maternity services including Ludlow MLU, looking at different ways to improve the service with different models of care.

Summary of findings

We saw several areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure patient records include all required information about the patient.
- Ensure there is an appropriate record of all medicines administered.
- The trust must review the risks relating to the environment of the MLU to ensure it is fit for the purpose of providing a homely environment for low risk women to give birth.

In addition the trust should:

- The trust should ensure there is an effective system in place to keep Ludlow MLU clean and dust free.
- The trust should ensure a record of the temperature where medicines are stored is maintained.
- The trust should ensure the unit safety dashboard is available and shared with staff.

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	Requires improvement 	Ludlow MLU did not fully reflect a “home from home” environment to provide a service focused on the needs of low risk woman. The environment was in poor condition, some equipment was not clean or dust free. The lack of an immersion bath meant that women could not receive low-level pain relief. Midwifery staffing arrangements meant that continuity of care during the women’s pregnancy by their named midwife was not possible. Patient records did not include all required information such medicines administered during labour and all patients observations. Medicines were managed well, although not all records of medicine administration were up to date and accurate and the temperature of the room where medicines were stored was not monitored. There was a lack of challenge by staff to ensure that the environment and equipment promoted the home from home of a midwife led unit. However, Ludlow Midwife Led unit provided opportunities for low risk woman in Ludlow and the surrounding areas who wanted to have their baby in a midwife led unit. Staff were caring and compassionate. Care and treatment was delivered in line the current evidence based guidelines. A full review of the maternity service was ongoing, looking at different ways to improve the service with models of care being considered by the trust

Ludlow Midwife Led Unit

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Detailed findings

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Background to Ludlow Midwife 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); 6,755 children live in poverty and life expectancy for both men and women is higher than the England average in Shropshire.

Ludlow Midwife Led Unit (MLU) is part of the Shrewsbury and Telford Hospital NHS Trust and is based within the Ludlow Community Hospital. The MLU team also provide community midwifery services. The original MLU was closed on 13 October 2016, due to the poor and unsafe condition of the premises. Alternative accommodation within Ludlow Community Hospital was identified and the MLU relocated and reopened on 7 November 2016.

We last inspected Ludlow MLU in October 2014 when we rated it as good.

Our inspection team

Our inspection team was led by:

Chair Nigel Acheson Medical Director NHS England South West

Inspection Manager: Debbie Widdowson, Care Quality Commission

The team included two CQC inspectors one of whom was a midwife.

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?

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

We carried out an unannounced inspection visit on 03 January 2017. There were no 'inpatient' women or babies at the time of our visit. We did speak with two women who attended the unit for antenatal / postnatal care and observed care provided during these appointments. We reviewed women's' maternity and delivery treatment and care records and spoke with four staff on the unit.

Detailed findings

Facts and data about Ludlow Midwife Led Unit

Ludlow MLU had 74 admissions between 01 November 2015 and 31 October 2016, the average length of stay was 2.5 days. In the same time period there was 23 transfers out to The Princess Royal consultant led unit; the main reason for transfer were recorded as delays in labour and foetal concerns.

There were 47 deliveries between 1 December 2015 and 30 November 2016. Between 1 November 2015 and 31 October 2016, 189 women received community postnatal care from midwives based from Ludlow MLU.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Maternity and gynaecology

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

Information about the service

Ludlow midwife-led unit (MLU) has one labour room and a four-bed bay for antenatal and postnatal care. A shared toilet and shower is available for women during their stay. The MLU team also provided community midwifery services

The MLU admits women who have been assessed as low risk and suitable to deliver their baby there. Some women who book and attend to deliver their baby in the MLU were transferred to the Princess Royal Hospital 35 miles away during labour when complications arose. The trust website identifies that the travel time by ambulance (including the time for the ambulance to arrive and for ambulance staff to get the patient ready to travel) was approximately 83 minutes.

There were 47 births at Ludlow MLU between 01 January 2016 and 31 December 2016. Between 1 November 2015 and 31 October 2016, there were 189 births within the community midwife area. In the same time, Ludlow MLU had 74 admissions, which included women who had chosen to give birth at the unit but were transferred to the consultant led unit, and those who chose to receive postnatal care as inpatients at the unit.

The MLU cares for women who have delivered at the consultant led-unit based at the Princess Royal Hospital (PRH) when they needed extra support with such things as breastfeeding.

One midwife, with a women's service assistant (WSA) were on duty during the day. A community midwife, who worked 7.5 hours each day, supported the unit as necessary. Outside these hours, one midwife was on duty with support of a WSA; a second midwife was on call to support with deliveries as the need arose. The unit manager worked mainly office hours although had two clinical shifts each week. We did not specifically inspect the community midwifery service during this inspection.

On the day of the inspection, there were no women or babies in the unit. We spoke with four members of staff, two women who had appointments on the unit for antenatal/ postnatal care and we reviewed three sets of patient notes.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- Ludlow MLU did not fully reflect a "home from home" environment to provide a service focused on the needs of low risk woman. The environment was in poor condition, some equipment was not clean or dust free. The lack of an immersion bath meant that women could not receive low-level pain relief.
- Midwifery staffing arrangements meant that continuity of care during the women's pregnancy by their named midwife was not possible.
- Patient records did not include all required information such medicines administered during labour and all patients observations.
- Medicines were mostly appropriately managed although not all records of medicine administration were up to date and accurate and the temperature of the room where medicines were stored was not monitored to ensure medicines safety and effectiveness.
- Although staff reported incidents, we were concerned that not all maternal transfers were being reported and opportunities for learning may have been missed.
- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.
- Identified risks such as the poor condition of the building and possible infection risks this identified were not adequately responded to in a timely way.
- There was a lack of challenge by staff to ensure that the environment and equipment promoted the home from home of a midwife led unit.
- There was inaccurate information for women on the trusts web site about facilities that were available at Ludlow MLU.

However:

- Ludlow Midwife Led unit provided opportunities for low risk woman in Ludlow and the surrounding areas who wanted to have their baby in a midwife led unit.
- Staff were caring and compassionate.
- Supporting Women with Additional Needs team provided support to both patients and midwives for the care and support of vulnerable women. Aqua natal and parent craft classes were invaluable to support women in the labour, birth and ongoing care of their baby.
- Care and treatment is delivered in line the current evidence based guidelines. Staff adhered to the trust Intrapartum Care on a MLU or Homebirth policy (June 2016).
- Effective systems of communication were established between the consultant led unit and the MLU, GPs and other health professionals ensuring that effective care and treatment was delivered.
- A full review of the maternity service was ongoing, looking at different ways to improve the service with models of care being considered by the trust

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Patient records were legible but did not include all required information such as patient observations.
- The environment was in poor condition, some equipment was not clean or dust free.
- Medicines were mostly appropriately managed although not all records of medicine administration were up to date and accurate and the temperature of the room where medicines were stored was not monitored to ensure medicines safety and effectiveness.
- Although staff reported incidents, we were concerned that not all maternal transfers were being reported and opportunities for learning may have been missed.
- Midwifery staffing arrangements meant that continuity of care during the women's pregnancy by their named midwife was not possible.
- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.

However:

- Staff had received safeguarding training and there were systems in place to ensure prompt referral of safeguarding concerns.
- There were appropriate systems in place to respond to emergencies.

Incidents

- The trust had an electronic system to enable staff to report incidents including near misses. The ward manager told us that in addition to electronic reporting, midwives would also call a senior midwifery manager to inform them of any serious incidents that may require immediate action. The ward manager said that staff classified the seriousness of the incident however, this was also reviewed by senior managers to ensure appropriate investigation and actions were being undertaken.
- All incidents reported by Ludlow MLU staff were reviewed and investigated by the ward manager. Staff told us they received feedback (when appropriate) when they had completed an incident report form.
- The trust provided us with details of all incidents reported between 1 November 2015 and 31 October 2016. During this period, there were 22 incidents reported by staff at Ludlow MLU. This included three incidents when suitably qualified staff were not available, five incidents where patients were transferred from Ludlow MLU to the consultant unit at Princess Royal Hospital and one workplace or environment problems.
- 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 23 women transferred to the consultant led unit between 1 November 2015 and 31 October 2016 and five 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.
- No serious incidents had been reported between 01 November 2015 and 31 October 2016. Staff we spoke with were clear about what constituted a serious incident.
- Learning from incidents both within the local team and from the trust was disseminated during staff meetings, this was confirmed by meeting minutes we looked at which are kept on a folder on the ward. This promoted cross unit learning.
- The ward manager was able to give us an example of learning from an incident. Following a delay in reviewing patient test results due to the named midwife not being available, staff on duty now review all test results and any urgent results so they are acted on the same day.
- We saw minutes from the perinatal mortality meetings, which showed that perinatal deaths were reviewed to identify both where good practice had been met and highlight any learning identified. Ludlow MLU was not represented at these meetings but the minutes were shared.
- There were no 'never events' reported by the MLU between 01 November 2015 and 31 October 2016. 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.

Duty of Candour

- Duty of candour is regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- There had been no incidents, which required duty of candour investigation between 1 January 2016 and 31 December 2016. The ward manager told us that all staff had received training in duty of candour as part of their mandatory training update.
- Staff were aware of their DoC responsibilities with regards to be being open and honest with the women in their care. The manager told us they also received support and advice from the lead community midwife in relate to actions required if mistakes were made.

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

- We observed all staff complying with the trust infection control policy. We saw staff regularly washed their hands and used hand gel. Hand gel was available at the entrance to the unit and at the end of every bed. The hospital's 'arms bare below the elbow' policy was met.
- There had been no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia 01 November 2015 and 31 October 2016.
- The ward manager told us that all staff had a hand hygiene assessment every three years to assess if staff were compliant with the trust policy. At the time of our inspection, records we looked at confirmed that all but two staff (due to long-term sickness) had a hand hygiene assessment.
- The ward manager did a monthly observation audit to assess if staff were compliant with the trust hand hygiene policy. The staff hand hygiene audit results were reported to the lead nurse for community midwifery services. Hand hygiene audit showed 100% compliance for the last 12 months when the unit was open and an audit was undertaken.
- Data requested from the trust showed that 82% of staff working at Ludlow MLU had completed infection prevention and control training.
- The MLU had fabric curtains the ward manager told us that the arrangements were made by the hospital site manager to launder all curtains every three months.

Environment and equipment

- An environmental infection control audit was carried out at the unit in December 2015. The audit identified that the building was old, in need of repair and routine maintenance and at risk of contamination. The report identified that following the previous infection control audit in September 2014, a plan had been put in place with the building's owner to address concerns but the plan had not been implemented. The December 2015 report identified that the building had deteriorated substantially since September 2014.
- Ludlow MLU closed on 13 October 2016, due to the poor and unsafe condition of the premises. Alternative accommodation within Ludlow Community Hospital was identified and the MLU relocated and reopened on 7 November 2016. However, we were concerned about

the condition of the "new" premises, which appeared also to be in a poor state of repair. For example, we observed that ceiling tiles appeared to be dirty and stained.

- There was dust on both the adult and neonatal resuscitation trollies. Staff told us that the trollies were not included within the MLU cleaning schedule and it was the responsibility of the women's services assistant (WSA) on duty to ensure they were kept stocked and clean. When we highlighted the trollies to staff, they were immediately cleaned.
- Staff told us that they had appropriate equipment to provide care and treatment for women booked as low risk for the MLU.
- The resuscitation (including the resuscitaire for babies) equipment was checked daily, records were signed to confirm this.
- A new born transfer pod was stored on the unit. Records showed this was checked daily by staff and signed as in order.
- We found the majority of electrical equipment had a recent portable appliance test. However, we found no record to confirm that some equipment such as a DVD player and cardiotocograph CTG machine and sonicaid had the required annual check in August 2016. We raised this as an urgent issue during our inspection as there was only one sonicaid and CTG available.
- The homebirth equipment carried by community midwives was checked every weekend and was re stocked after each home birth weekly.
- The MLU was a locked environment, visitors had to ring a bell for staff to open the door and check visitors before they entered to safeguard mothers, babies and staff working on the unit.

Medicines

- We observed that all medication was stored appropriately. However, there was no record made of the temperature of the room where medicines were stored. Medicines should be stored at the required temperature to provide assurance of the effectiveness of the medicine.
- Registered midwives may supply and administer, on their own initiative, any of the substances that are specified in medicine's legislation under midwives' exemptions. We viewed three prescription records and found that midwives had not consistently prescribed medicines given in labour such as Entonox (gas and air) on two of the treatment charts we looked at when compared to the woman's labour record. This is against medicines legislation, Nursing and Midwifery Council (NMC) practice standards.
- Patient Group Directives (PGDs) were in place on the unit. A patient group direction allows some registered health professionals (such as nurses or midwives) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. Staff told us the PGDs had recently been updated and they had signed to confirm they had the updated requirements.
- To take out (TTO) medication was arranged on transfer to the MLU, or faxed from the consultant led unit when required.
- We saw controlled drugs were checked during the handover process, two midwives ensured the count was correct. Records showed this occurred twice a day.
- A controlled drugs audit was conducted in November 2016. The results of this showed the MLU to be compliant with good practice guidelines.
- A medication audit carried out in November 2016 found Ludlow MLU was mostly compliant with the safe storage and administration of medicines. Three issues were identified these included: a need for recorded checks to room temperature where medicines were stored, a new lock to the medicines storage room (which has been completed) and clarification of a master key for individual patient medicine storage cupboards and this had also been actioned.

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 unit manager told us that the MLU did a monthly audit of up to ten patient records each month to measure compliance with maternity guidelines. The trust provided us with a copy of the summary report for July to December 2016. The results of the review demonstrate a compliance of 75% or better in 55 (90%) of the 61 standards reviewed. Of these, 24 (39%) met a compliance of greater than 90%. The standards where compliance was found to be below 75% were carbon monoxide monitoring and referral to smoking cessation

services at booking; palpation prior to vaginal examination; vaginal examination offered hourly in the second stage of labour and designation recorded by midwife when note keeping.

- The service conducted a records' audit in November 2016, which included five sets of patient records from Ludlow MLU. A total of 45 records from other areas across the service were also included. The results of the audit showed that records were appropriately kept. However, improvements were required to ensure the patient's name and unit number were consistently used and that entries were in chronological order. There was also a recommendation to review storage arrangements for assessments and investigations.
- We saw that patients' paper records were stored securely in a locked cupboard within the midwife office.
- We reviewed three patient records, which included information about test results, scan information and discussions with the women in their care. The notes were legible and current. However, records did not include all required observations. We found in one of the three patient records there was an early warning score but not all observations had been recorded which made the score inaccurate. The second set of patient's records did not have the early warning score recorded.
- We saw that risks were assessed during appointments and documented clearly within the patient records we looked at.
- There was a standard operating procedure in place for staff giving telephone advice to women. The procedure advises staff to record the contact on the electronic recording system, where possible, or a telephone triage card. The ward manager told us at Ludlow all telephone calls were recorded on the triage form as It connectivity was an issue. We did not directly observe any staff taking calls during our inspection.

Safeguarding

- Arrangements were in place to safeguard women and babies from abuse and reflected safeguarding legislation and local policy.
- Staff told us they felt very well supported by the safeguarding lead for the unit who attended the monthly Safeguarding Women with Additional Needs (SWAN) meetings.
- The trust target for staff completion of safeguarding training was 100%. At the time of the inspection 100% of staff had completed safeguarding adults training, 88% of staff had completed safeguarding children training to level 2 and 88% of staff had completed safeguarding children level 3.
- 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.
- 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.

Mandatory training

- There was a 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 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 stabilization. Compliance rates for all modules were provided at service level only and not brokn down by unit. Electronic fetal monitoring was recorded at 80% and care of the severly 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%.
- The statutory mandatory training programme included 16 topics such as patient moving and handling, adult basic life support, slips trips and falls and equality and diversity. At Shrewsbury MLU this was completed during a 'three day' annual mandatory training programme.
- Trust mandatory training completion target was 100%. At the time of the inspection, compliance with mandatory training at Ludlow MLU was reported as 71%.
- Compliance with basic life support training was 71%. Advance life support for adults was not mandatory for midwifery staff.

- The unit also carried out 14 live skills training sessions in 2016.

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 described this policy and confirmed that risks were discussed with women at each stage of the process. Records we looked at confirmed that this criteria was being followed.
- 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.
- 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.
- 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 one community midwife would attend with a second attending for the delivery of the baby. If a home birth was against medical advice, two midwives would attend the entire labour to support and provide professional advice throughout. We saw that an on call system was in place for the time around the due date in order to facilitate this.
- In maternity services the Modified Early Obstetric Warning Score (MEOWS) and Newborn Early Warning Score (NnEWS) system were in place for women and babies.
- Staff told us and we saw that the MEOWS was used to monitor women during ante-natal care and post delivery. The use of a MEWS score would help to identify if the woman's condition had deteriorated. However, we found in one of the three patient records the MEOWS score had not been recorded.
- The new-born's observations were recorded at the time of delivery. The ward manager told us that only if there were signs of the baby's deterioration would a new-born early warning score (NnEWS) be assessed Staff were clear about actions they would undertake to escalate any concerns.
- 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.
- Staff were clear of the procedure for managing 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 that the woman was on the way. 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. A review of all incidents that involved the transfer of women in labour was undertaken to assess that woman had received appropriate care and timely transfer when needed.
- Between 1 November 2015 and 31 October 2016, there were 23 transfers out to consultant led unit. The main reasons for transfer were recorded as delays in labour and foetal concerns.
- A service-wide review of transfers by ambulance to the CLU between April and September 2015 concluded that women were not being unnecessarily transferred and outcomes for those who were transferred were good.
- A newborn transfer pod was kept on the ward to ensure babies requiring transfer were transferred safely.
- 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 91 women transferred for post natal care between 1 November 2015 and 31 October 2016.

Midwifery staffing

- There were 11 midwives working at the unit (7.5 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, they would be supported during the day by either the community midwife or ward manager.
- Out of hours, there was a rota with one midwife on call during the night who may be called to assist with the second stage of labour. An acuity tool was used to record staffing levels and the manager sent reports monthly for this to be reviewed.
- The unit had closed on four occasions overnight as there was either insufficient staff at Ludlow MLU or Ludlow midwives were needed to support the consultant unit. On these occasions women who may deliver were contacted and told if they went into labour, they should contact either labour ward at Princess Royal Hospital or Bridgnorth MLU.
- If a home birth was planned, a rota was put into place for two midwives to be on call for up to four weeks. The midwife on duty in the MLU would go out to the woman at home with cover for the unit provided by the first midwife on call. The second on call midwife would then go to the home birth to assist with the labour and delivery of the baby.
- The ward manager told us that from early November 2016 until the end of March 2017 there was a need for two midwives to be on call to support women who had requested a home delivery. The ward manager told us that this had put immense strain on their small staff group as midwives had to be within 30 minutes of the MLU when they were on call and this had affected their personal lives. When two midwives were on call (for a home delivery) this meant they were on call two or three times each week. Midwives on call could be called out during the night and then by on shift the following day.
- There were a total of six (four whole time equivalents) Women's Services Assistants (WSA) and one health care assistant (0.4 whole time equivalent) 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.
- In addition to staffing the unit, the midwifery team provided a community service, covering a large rural area. One midwife provided this service.
- Staff told us that a handovers took place with at the beginning of each shift and provided information about woman and babies in their care.
- The ward manager told us as the majority of the staff were part time they were able to cover sickness and annual leave within their team although bank staff were used if their own staff were unable to cover shifts. Between 1 November 2015 and 31 October 2016, there were 52 hours at Ludlow MLU covered by bank midwives.
- The team used a named midwife system with an identified midwife linked to a GP practice(s). Staff said that the named midwife would ensure that women had all the required checks and would follow up any test results. Staff told us that whenever possible when they were on duty, they would attend the antenatal clinic for their GP practice. However, the impact of the on call system meant it was not always possible to do this. One woman we spoke with did not know that they had a named community midwife and told us that they had not seen the same midwife throughout her pregnancy.

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 Princess Royal Hospital and, where necessary, follow protocols for transfer to the hospital.

Major incident awareness and training

- Fire safety awareness training was included as part of the staff mandatory training course. The ward manager told us that staff attended fire training within Ludlow Community Hospital as this ensured that the training related to their place of work. Staff told us fire drills were conducted annually.
- The trust had a major incident and business continuity plan should the need arise. Recently the MLU had closed overnight due to exceptional activity within the consultant unit, to safely meet staffing requirements.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line the current evidence based guidelines. Staff adhered to the trust Intrapartum Care on a MLU or Homebirth policy (June 2016).
- 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.
- Pain relief was discussed with women and administered in line with their birth plan where possible.
- There were good arrangements in place to support breast-feeding.
- Verbal consent was gained between the mother and midwife during examinations and the recording of observations.

However

- The lack of an immersion bath meant that immersion in warm water could not be used for pain relief.

Evidence-based care and treatment

- We saw that staff had access to guidance, policies and procedures through the trust intranet. The ward manager told us that they encouraged staff to refer to the intranet policies to ensure they referenced the most up to date policies.
- There was an operational policy for the unit that identified the criteria for low risk mothers who were suitable to have their babies at the unit. A copy of the policy was available on the unit. We saw that a copy was laminated on the wall for staff to refer to during the booking visit and during antenatal checks.
- We saw that midwifery meetings' records (a record was kept in a folder on the MLU for staff reference) also identified which policies had been updated to signpost staff to check any changes made.
- We saw that in line with National Institute for Health and Care Excellence (NICE) Intrapartum Care Guidelines (2014), staff adhered to the trust ' Intrapartum Care on a MLU or Homebirth policy' (June 2016). This ensured low risk women, who chose to give birth at home or in a MLU, received safe, evidenced-based care.
- The service audited compliance against NICE guidance on an annual basis.
- 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 their pregnancy.
- A risk and needs assessment including obstetric medical and social history was carried out, to ensure that woman had a flexible plan of care adapted to her own antenatal care requirements in line with Royal College of Obstetricians and Gynaecologists 2008 guidelines (RCOG 2008).
- 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. Staff told us they supported women with breastfeeding and caring for the baby on the unit. Comments in the visitors' book and in the patient experience survey also demonstrated this.
- Nursing and Midwifery Council (NMC) guideline meetings were held monthly. Two midwives reviewed new guidelines to ensure they reflected current practice; these were also discussed at maternity feedback meetings.
- We saw minutes of the monthly guideline meetings where two 'guideline midwives' discussed new guidance in line with NICE.

Pain relief

- Staff told us pain relief was discussed with women and administered in line with their birth plan where possible, records we looked at confirmed this.
- Staff told us that women were offered access to various sources of pain relief such as entonox and pethidine. The MLU also had midwives qualified to provide hypnotherapy and other complementary therapies to provide alternative pain relief.
- The MLU had no bath/ birth pool, which women in labour could use to reduce pain and discomfort. Research identifies that immersion in warm water can provide effective pain relief for women in labour.

- The trust's inpatient survey in August, September and November 2016 identified that 100% of women had their pain controlled. In October 2016, 87% of woman said their pain was controlled.

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.
- Breast-feeding of the newborn was promoted on the unit. A lactation consultant was available to support women and offer advice to the midwives when breast-feeding was not possible.
- 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.
- Staff told us that patient food which was cooked in the hospital kitchen and a choice was always available and when needed special diets were catered for.
- Sterilisers and baby formula milk were available but mothers were asked to bring their own if unable or choose not to breast feed.
- Hot and cold drinks were available throughout the day. There was a small ward kitchen for staff to use. However, staff told us the kitchen could not be used by women or their partners to make their own drinks and snacks. This meant patients and their partners were unable to access drinks and snacks if staff were busy.

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 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.
- 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%. The data provided was trust-wide and not broken down by unit. We were unable to determine the midwife to birth ratio for Ludlow MLU.
- During 2016, the service introduced a maternity dashboard that identified key performance indicators and patients outcomes benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard.
- Results for Ludlow MLU showed that between April and November 2016 there had been zero women who had an episiotomy and zero women who had a third or fourth degree tear and no identified low birth weight (less than 2.5 kgs) or high birth weight babies(more than 4kgs) in the same time frame.
- The MLU register identified that two woman and one baby had been readmitted to Ludlow MLU between 1 January 2016 and 31 December 2016. We saw that the readmissions were to support and establish breast-feeding.
- The national target for booking appointments was 12 weeks and this was being achieved.

Competent staff

- Midwives were rotated from the MLU. 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.
- Post inspection, the trust provided us 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.

- 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.
- Data provided showed that 14 out of 15 (93%) staff had received their appraisal at the time of the inspection.
- Staff told us they had regular supervision and that they could access time with a supervisor, as they required.
- There was an induction pack prepared for new members of staff to work through. The induction included a walk around the unit, information about the patients, general practices within the area and the day-to-day working of the unit. The manager told us that new staff had an induction period for up to one week.
- A preceptorship package was in place for newly qualified midwives, which included a specific structured rotational programme. This process ensured that the midwifery workforce maintained their skills and provided flexibility with service provision.
- Staff told us they were supported to complete training and keep up with competencies for skills. We saw that equipment was available for staff to practice skills such as perineal repair.

Multidisciplinary working

- Staff told us that there were good multidisciplinary working arrangements between the community midwives, health visitors, GPs and social services staff.
- 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 working relationships were effective.
- 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.

Seven-day services

- The MLU was open 24 hours per day, seven days per week, which enabled women to attend or telephone for advice.
- An on call system was in place to ensure that for women reaching the second stage of labour 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. Staff told us that information technology access was slow at the unit and they were frequently frustrated by the poor IT and at times were unable to access the trust intranet.
- There was a back-up folder available on the unit with information, which included the latest good practice findings and any updates to policies and procedures issued throughout the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they provided as much information as possible before gaining consent. We observed and records showed that verbal consent was gained between the woman and midwife during examinations and the recording of observations.
- Staff were aware of the procedure to follow regarding the Mental Capacity Act. Information received from the trust showed that eight staff at Ludlow MLU had received training in the Mental Capacity Act.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Feedback from women identified positive care experiences at Ludlow Midwife Led unit.
- 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.
- Feedback we saw identified that 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 spoke with one woman who said, "Staff on the unit here are really nice". Entries in the visitors book for December 2016 included, "the expertise and support offered here in such a friendly and non-clinical environment is so valuable and has once again enabled me to return home with positivity and equip me to enjoy my new family". "How many lives have you touched with your wonderful compassionate care"? "The staff here are caring supportive and knowledgeable and provide excellent care. The breast feeding support is essential".
- The trust performed similar to other trusts for 15 out of 16 questions in the CQC Maternity and Gynaecology Maternity survey 2015.
- The inpatient survey for Ludlow MLU identified that 100% of women who completed the survey in August, September, October and November 2016 were treated with kindness and compassion and had their privacy and dignity maintained.
- We observed one patient consultation, we found the midwife was caring but the appointment was rushed and they did not take the opportunity to provide health promotion advice.

Understanding and involvement of patients and those close to them

- Staff told us that they encouraged women to identify a birth/ care plan, which they supported women to achieve.
- We spoke with one woman who told us they had good support from the community midwives from the MLU with breast-feeding. The trust's maternity inpatient survey identified that 100% of women who completed the survey in September and November 2016, 92% in August 2016 and 87% October 2016 that the nurse (midwife) had talked to them about what was happening.
- Staff told us that the partners were encouraged to be involved during the delivery and following the birth. The trust website identified that partners were able to stay overnight whilst the women was in labour and for the delivery of the baby to provide her with support.
- The trust's maternity inpatient survey identified that 100% of women said that staff treated their partners professionally. Staff told us additional support was offered to women when required and they were encouraged to ring in to the unit with any queries.

Emotional support

- Staff told us that women were monitored for their wellbeing at all stages of the pregnancy and following the birth.
- We saw that assessments for anxiety and depression were recorded throughout their care. Staff told us that woman were given written information raising awareness of mental health, their feelings and any support needed.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Ludlow Midwife Led unit provided opportunities for low risk women in Ludlow and the surrounding areas who wanted to have their baby in a midwife led unit.
- The service provided 24 hours care and advice to women who had any concerns about their pregnancy.
- The Supporting Women with Additional Needs team provided support to both patients and midwives for the care and support of vulnerable women.
- Aqua natal and parent craft classes were invaluable to support women in the labour, birth and ongoing care of their baby.
- The MLU had good multidisciplinary working with other services and professionals.

However:

Ludlow MLU did not fully reflect a "home from home" environment to provide a service focused on the needs of low risk woman.

Service planning and delivery to meet the needs of local people

- The MLU promoted 'home from home' experience for women within the local community. However, we found that it needed to be made more homely.

- Between November 2015 and October 2016, there were 47 births at Ludlow MLU and 116 admissions. This included women who had chosen to give birth at the unit but were transferred to the consultant unit and those who had received postnatal care. Midwives based at the unit also provided community care to the local area. During the same time, there were 270 births within the community midwife area.
- 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 at a local community centre 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.
- Community midwives ran 'aqua natal classes' for antenatal women at a local leisure centre. Staff told us that women were given information and a leaflet about the aqua natal classes at their first antenatal booking appointment.

Access and flow

- Women could access the maternity services for antenatal care via their GP or by contacting the community midwives directly.
- Low risk women wishing to deliver their baby on the unit were booked at their first antenatal appointment. Other admissions to the unit for example for post-natal care following discharge from the consultant unit were booked either from the woman's place of delivery or by their GP.
- 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.
- The original MLU was closed on 13 October 2016, due to the poor and unsafe condition of the premises. Alternative accommodation within Ludlow Community Hospital was identified and the MLU relocated and reopened on 7 November 2016. Ludlow MLU had also closed on four other occasions due to staffing issues within both Ludlow MLU and when staff at Ludlow MLU were required to work at the consultant unit at Princess Royal Hospital. During the time, the unit was closed staff told us that women were informed and were given the option to deliver their babies either at Princess Royal Hospital, Bridgnorth MLU or if they preferred at home. Community midwives continued to provide antenatal and postnatal care to woman either at their GP surgery or within their own home during that time.

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.
- Midwives undertook a home visit when women were 24 weeks pregnant. Staff showed us the pack that they gave out during the 24-week home visit, which included information about breast-feeding support, parent craft classes, aqua natal, whooping cough vaccination, actions if a woman experienced reduced foetal movements and other frequently asked questions. We found these home visits to be good practice when women had increased time to discuss support and other concerns they may have.
- 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.
- The MLU was clinical and needed to be made more homely. The delivery room was small without pictures or softened lighting and had limited space for the woman to move around in labour.
- Ludlow MLU had a shower but there was no immersion bath or birthing pool available to provide pain relief in labour. The ward manager had raised funds for a birthing pool and plans were being considered for its use.
- There were monthly meetings of the Supporting Women with Additional needs (SWAN) team to discuss and plan the care and support for all women who had been referred. Staff told us that they could refer women with additional needs, which may include teenage mothers, women with mental health needs, drug or alcohol addiction or women living with a learning disability or subject to domestic violence.
- Staff told us they 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.

- The ward manager told us that they were able to use an organisation to support woman living with a learning disability with one to one teaching, information and support with their pregnancy, birth and ongoing care of their baby.
- The community around Ludlow MLU was mostly rural. The MLU had a four-wheel drive vehicle to enable community midwives to access remote patient homes. Staff told us they had used the four-wheel drive vehicle to get to a woman in labour who lived in a wood.
- 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.
- 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 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. No complaints had been received at the unit during the previous 12 months. When issues or concerns were raised the team discussed these at ward meeting to minimise the likelihood of them re-occurring and ensure there was shared learning.
- Information and posters on how to complain signs were displayed on the unit.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Identified risks such as the poor condition of the building and possible infection risks this identified were not adequately responded to in a timely way.
- There was a culture of 'acceptance 'by staff and not one to champion that the building and equipment available provided women with the high quality care.
- There was inaccurate information for women about facilities that were available at Ludlow MLU on the trust's web site.

However:

- A full review of the maternity service was ongoing, looking at different ways to improve the service with models of care being scoped by the trust.
- Staff demonstrated the values of the trust and the service.
- Staff felt supported by both the unit and lead midwife for community services.

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 to 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.
- Midwifery staff spoke positively about managers of all levels in the service and told us they were visible and they felt well supported.
- The HoM had visited the unit and staff told us she was approachable and they felt they could raise issues.
- Staff told us they felt the trust executive board were visible, they were aware of who they were and said that some members such as the Chief Executive had been to the unit.
- Local leadership was described as supportive and approachable. Midwives told us that they were confident that they were listened to.

Vision and strategy for this service

- 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.

- There was a full review of the maternity service across the trust in progress. The purpose of this was to consider ways the service could be developed and improved. Midwives had mixed feelings about the review although all said that the uncertainty was unsettling until a definite decision was made. Staff told us the review was identified for completion in April 2017.
- The staff told us the vision for the unit included extending services such as water births and offering more choice in labour for women. However, staff were unclear of the future of the unit.

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. The trust risk register included two risks, which named Ludlow MLU these were: a lack of 'baby tagging' at Ludlow MLU and concerns about the building. Risks and responsible owners were appropriately assessed, reviewed and escalated. We saw there was a maternity governance action plan tracker in place, which monitored the progress of actions undertaken.
- The poor state of the building at Ludlow MLU was originally identified as a red risk but has been downgraded since the relocation of the unit. However, the risk register recorded that the risk would continue to be reviewed by the women and children's directorate at the monthly risk meetings.
- 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.
- We saw minutes of the monthly ward meetings were available for staff to receive updated information about and any quality and safety issues such as incidents and changes to practice and when needed any learning was identified.

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 unit and the care it provided.
- It was evident that staff were committed to the unit; however, shortfalls of the building and the service were accepted and not challenged by staff. One staff member said. "We know it (the building) is not perfect but it's ours".
- Some staff said they were uncertain about the future of the unit although all acknowledged a need for change.

Public engagement

- We saw survey forms for women to complete to provide feedback to staff working on the unit. The ward manager told us that they encouraged women to complete these forms to ensure that any improvements could be made and positive experiences could be identified.
- The trust ensured that press releases were made to update women about closures to Ludlow MLU and other any changes to the unit.
- The trust website gave inaccurate information about services that were provided at MLUs including Ludlow MLU. Information detailed, "We are now pleased to offer water births at the Unit". In addition, the web site identified that labour aids such as mats, beanbags, a chair bed for partners, dimmed lighting, music and a television were available. However all this information was not accurate.

Staff engagement

- The unit had monthly ward meetings. The ward manager told us and minutes we looked at confirmed that the meeting were well attended by the staff team.

Maternity and gynaecology

- We saw information displayed by the ward manager on the noticeboard and from across the trust in the "chatterbox" newsletter and Head of Midwifery updates.
- The Head of Midwifery wrote a monthly newsletter across the trust to keep staff up to date with maternity department information.
- Staff told us that the Chief Executive, Head of Midwifery and lead midwife for community services had all recently attended the unit to discuss the closure and relocation of the unit.

Innovation, improvement and sustainability

- The trust was reviewing the provision of maternity services. Proposals for alternative models of a modern, safe and effective midwifery service were being considered and this included Ludlow MLU.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure patient records include all required information about the patient.
- The trust must ensure there is an appropriate record of all medicines administered.
- The trust must review the risks relating to the environment of the MLU to ensure it is fit for the purpose of providing a homely environment for low risk women to give birth.

Action the hospital SHOULD take to improve

- The trust should ensure there is an effective system in place to keep Ludlow MLU clean and dust free.
- The trust should ensure a record of the temperature where medicines are stored is maintained.
- The trust should ensure the unit safety dashboard is available and shared with staff.