

Gloucestershire Hospitals NHS Foundation Trust Stroud Maternity Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Good



Maternity and gynaecology

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Stroud Maternity Hospital is one of the hospitals run by Gloucestershire Hospitals NHS Foundation Trust. It provides maternity services to the local community of Stroud and the surrounding areas. Maternity services are also provided at Gloucestershire Royal Hospital and Cheltenham General Hospital. The service is run by the same management team (within the women's and children's division) across the whole of Gloucestershire Hospital NHS Foundation Trust, and, as such, is largely regarded within the trust as one service. For this reason, some duplication within the three reports is inevitable.

Stroud Maternity Hospital is a stand-alone midwife-led unit with 10 beds and is located 11.5 miles from the main obstetric unit at the Gloucestershire Royal Hospital.

We inspected Gloucestershire Hospitals NHS Foundation Trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a low-risk trust according to our new intelligent monitoring model. The inspection took place on 10–13 and 20 March 2015, and we visited this hospital on 12 March 2015.

Overall, this hospital was rated as good.

The trust's services are managed through a divisional structure that covers all the hospitals within the trust, with some staff rotating between the three sites; therefore, there are significant similarities between the content of the three location reports.

Our key findings were as follows:

- There was a good culture of incident reporting, openness and learning.
- Whilst trust-wide staffing levels were worse than the England average, there were sufficient staff to meet patients' needs, with one-to-one care provided to all women in labour at Stroud Maternity Hospital.
- Risks were managed well, including those around access to the maternity unit, and staff were trained to manage care in the event of an obstetric emergency.
- Infection control risks were not fully addressed, with no process in place to identify whether equipment had been cleaned and was ready for use.
- Medicines were not securely stored nor held within tamper-proof containers, and staff did not follow the trust's policy on safe administration of medicines.
- Staff received training in safeguarding vulnerable adults and children and recognising abuse.

Systems were in place to identify women and babies at risk, including at risk of domestic violence.

The maternity unit employed a lead midwife in safeguarding as well as midwives specialising in substance misuse and teenage pregnancy. These were available for support and advice to midwives working in Stroud and the surrounding community.

- Care and treatment delivered was evidence based, with policies and guidelines developed in line with national guidance.
- A wide range of pain relief was available, including massage, essential oils and water.
- Family of origin questionnaires were completed to identify women at higher risk of sickle cell disease and thalassemia. The percentage of these women being screened at under 10 weeks' gestation was not reported on the dashboard. However, two audits had identified only 33% of high risk women were completing the family of origin questionnaire, and therefore opportunities for early screening undertaken before 10 weeks' gestation were missed.

Summary of findings

- The transfer rates to the main obstetric-led unit were reported as marginally below the national average, at 24.6% compared with the national rate of 26.4% as reported in the Birthplace study.
- Care was seen to be delivered with kindness and compassion. Women were involved in decision making. Patients and their relatives had a good understanding of and described feeling involved in the care.
- Women were supported to make choices on where to have their babies. The service ran home births as well as births in the maternity unit.
- Translation services were provided by a telephone translation service. Leaflets were available in alternative languages, although these were not immediately available for midwives to give women but had to be ordered in.
- The service had a well-defined governance structure with a good connection to the board. Activity, quality and risk were monitored and reported on; however, actions to address risks were not recorded on the risk register. Specialist midwives were employed to support the governance function.
- Staff actively promoted the Mums Up and Mobile (MUM) project to promote normality in labour and through supervision women were supported with their birth choices.

We saw several areas of outstanding practice including:

- Staff actively promoted the Mums Up and Mobile (MUM) project, which had also been presented nationally at midwifery conferences. Through supervision, women were supported with their birth choices.

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

Importantly, the trust should:

- Review the storage of emergency drugs to ensure they are accessible but safely stored, checked and tamper evident.
- Ensure all staff are trained in the safe storage, handling and administration of medicines.
- Ensure systems are in place so staff know when equipment has been cleaned and is ready for use.
- Review the processes to ensure early screening (pre 10 weeks' gestation) can occur where the need is indicated.
- Review the timeliness of access to patient information in alternative languages.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Maternity and gynaecology

Rating

Good



Why have we given this rating?

Safety, effectiveness, caring, responsiveness and well led domains were all rated as good.

There was a good culture of incident reporting, openness and learning with sufficient staff to meet patients' needs and staff were trained to manage care in the event of an obstetric emergency. Infection control risks were not fully addressed and medicines were not managed safely. Care was given in line with national guidance and delivered with kindness and compassion. There was good understanding and strong patient and public engagement. Services were delivered in a way that met the needs of the local population as well as individual patients who were well supported with their birth choices.

Stroud Maternity Hospital

Detailed findings

Services we looked at

Maternity and gynaecology

Detailed findings

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Background to Stroud Maternity Hospital

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services to a population of around 612,000 people in Gloucestershire and the surrounding areas.

The trust has three main locations that are registered with the Care Quality Commission, which are Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital. There are 1,072 beds across these three hospitals. The trust has six further locations registered at which it runs outpatient clinics and provides imaging services. There are 10 beds at Stroud Maternity Hospital.

The trust was formed in 2002 with the merger of Gloucestershire Royal and East Gloucestershire NHS Trusts, and became an NHS foundation trust in July 2004.

Deprivation in Gloucestershire is lower than average. Gloucester is ranked 142 out of 326 local authority districts across England in the Index of Multiple Deprivation. The other districts are less deprived, with the Forest of Dean at 164, Cheltenham 214, Stroud 255, Cotswold 263, and Tewkesbury ranked least deprived at 275. Life expectancy for both men and women is higher than the England average.

According to the last census, in all the districts in Gloucestershire the proportion of black, Asian and minority ethnic (BAME) residents is less than the England average, ranging from 11.0% in Gloucester to 1.6% in the Forest of Dean. The percentage of residents aged 65 years and over is higher than the England average of 17.3% in the Forest of Dean (22.3%), Stroud (20.9%), Tewkesbury (21.4%) and Cotswold (23.9%).

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a low risk trust according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

The inspection team inspected one core service at Stroud Maternity Hospital:

maternity service.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Specialist clinical advisor

Head of Hospital Inspections: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant obstetrician and a midwife.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the local commissioning group, Monitor, the local council, Gloucestershire Healthwatch, the General Medical Council, the Nursing and Midwifery Council, and the royal colleges.

We held two listening events, one in Gloucester and one in Cheltenham, on the 25 February 2015, at which people shared their views and experiences. More than 35 people attended the events. People who were unable to attend the event shared their experiences by email, telephone and on our website.

We carried out an announced inspection on 10–13 March 2015 and an unannounced inspection at Gloucestershire

Royal and Cheltenham General Hospitals on 20 March 2015. Our visit to Stroud Maternity Hospital took place on 12 March 2015. We held focus groups and drop-in sessions with a range of staff in Stroud Maternity Hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with patients and staff from across most of the trust. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

Facts and data about Stroud Maternity Hospital

Overall, Gloucestershire Hospitals NHS Foundation Trust has 1,072 beds, about 7,400 staff and provides acute healthcare services to a population of around 612,000 people in Gloucestershire and the surrounding areas. There are 10 beds at Stroud Maternity Hospital.

In 2013/14, the trust had more than 108,000 inpatient admissions including day cases. From December 2103 to November 2014, there had been 773,447 outpatient attendances (both new and follow-up) and 124,904 attendances at urgent and emergency care. There were 6,276 births across the trust.

At the end of 2013/14, the trust had a financial surplus of £3.59 million.

Bed occupancy was constantly over 91% in 2013/14. It was above England average (85.9%) all year and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of a hospital.

Gloucestershire Hospitals NHS Foundation Trust has a stable executive team, with the chief executive, nursing director, medical director, director of clinical strategy and director of human resources and organisational development all having been in post for over six years. The non-executive team is also stable, with the chair having been in post since 2011.

CQC inspection history

Gloucestershire Hospitals NHS Foundation Trust has had a total of nine inspections since registration. None of these have been at Stroud Maternity Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Maternity and gynaecology

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

Information about the service

Stroud Maternity Hospital provides maternity services to the local community of Stroud and the surrounding areas. The main hospital in Stroud was previously part of another trust; however, the maternity services became part of the Gloucestershire Hospitals NHS Foundation Trust in 2011. The service is run by the same management team (within the women's and children's division) across the whole of Gloucestershire Hospitals NHS Foundation Trust and, as such, is largely regarded within the trust as one service. For this reason, some duplication within the three reports is inevitable.

Stroud Maternity Hospital is a stand-alone midwife-led unit 11.5 miles from the main obstetric unit at Gloucestershire Royal Hospital. The unit comprises two clinic rooms used by community midwives and by visiting consultants who hold weekly outreach antenatal clinics there, a four-bed ward providing postnatal care, two en suite side rooms and two delivery rooms, both equipped with pools. In addition, on the delivery wing is a third room which, though smaller than the other two and without en suite facilities, can be used as a delivery room. This contains a traditional delivery bed, used if perineal suturing is needed.

Community midwives have storage facilities and are able to provide some postnatal care at the unit.

The number of births occurring between 1 April 2013 and 31 March 2014, and for 1 April 2013 to 30 November 2014, including home births for the whole of the Gloucestershire Hospitals NHS Foundation Trust midwifery service were:

April 2013 to March 2014

Stroud stand-alone midwifery-led unit - 216

Home (trust wide) - 164

April 2014 to November 2014

Stroud stand-alone midwifery-led unit - 187

Home (trust wide) - 106

During the inspection, we spoke with three patients, two relatives and six staff. We held a variety of focus groups, including one attended by nine midwives from across the whole of the maternity service. In addition, we reviewed one patient's healthcare records and observed care being given. Before and during our inspection we reviewed the trust's performance information.

Maternity and gynaecology

Summary of findings

Safety, effectiveness, caring, responsiveness and well led domains were all rated as good.

There was a good culture of incident reporting, openness and learning with sufficient staff to meet patients' needs and staff were trained to manage care in the event of an obstetric emergency. Infection control risks were not fully addressed and medicines were not managed safely. Care was given in line with national guidance and delivered with kindness and compassion. There was good understanding and strong patient and public engagement. Services were delivered in a way that met the needs of the local population as well as individual patients who were well supported with their birth choices.

Are maternity and gynaecology services safe?

Good



Safety within was rated as good. There was a good culture of incident reporting, openness and learning. Whilst trust-wide staffing levels were worse than the England average, there were sufficient staff to meet patients' needs. Risks were managed well, including access to the maternity unit, and staff were trained to manage care in the event of an obstetric emergency.

However, there were no process to identify whether equipment had been cleaned and was ready for use. Medicines were not securely stored nor held within tamper-proof containers, and staff did not follow the trust's policy on safe administration of medicines.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system that was available in Stroud Maternity Hospital, although the system was not immediately accessible to staff working in the community who did not have immediate access to the trust's intranet.
- A trust-wide list of incident categories and maternity-specific categories gave staff clear guidance on what constituted an incident, for example third and fourth degree tears, transfers to the main obstetric unit and post-partum haemorrhages.
- Two serious incidents had been reported within the maternity service within the trust since April 2014. These serious incidents had not occurred at Stroud Maternity Hospital. However, staff were able to describe changes that had occurred as a result, for example reviewing foetal heart traces within 10 minutes of commencing the recording; this was to be supported by the use of a sticker 'aide memoire', which was soon to be introduced across the whole of the maternity service.
- Less serious incidents were investigated by the midwife with lead responsibility for Stroud Maternity Hospital. All incidents described as moderate were reviewed by the lead nurse/midwife for quality and governance and a

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root cause analysis was commissioned. Actions identified were monitored for completion through the maternity clinical governance group. These were fed up into the divisional board governance meetings.

- There had been no incidents described as 'red' (that is, meeting the trust's threshold as a serious incident requiring investigation) within Stroud Maternity Hospital since April 2014. However, the process for escalation and review was the same across the whole of the maternity service within the trust. The lead midwife for quality and governance, senior managers and clinicians undertook a rapid review and escalated the incident to trust level. Investigators were then identified, including someone external to the division, and a full investigation took place. Actions identified were monitored for completion through the maternity clinical governance group, which fed up into the divisional board and on to the trust-wide safety experience review group, a subgroup of the board with overall responsibility to review that safety measures were in place. Following a previous serious incident where communication had been identified as an issue, staff undertook a 'look back' exercise, reviewing all low risk care with an adverse outcome. Using a template to ensure consistency, cases were reviewed systematically. Themes identified included communication, resuscitation and gaps in policies. Actions were developed and signed off as complete by the trust-wide safety experience review group.
- Staff received feedback following moderate and serious incidents. This occurred at department meetings as well as via newsletters such as the 'maternity and newborn' newsletter, which also detailed activity, birth outcomes and changes to practice such as the commencement of intermittent auscultation (listening to the fetal heartbeat) stickers for use in labour, which reduced risks by providing action prompts for midwives.

Duty of Candour

- Staff were aware of the duty of candour and told us how women were informed about incident investigations and outcomes. Letters were sent to women at 10 days in line with the trust's policy. In the event of a serious incident, staff told us women and their families would be invited in for face-to-face meetings and discussions.

Safety thermometer

- The maternity unit participated in the NHS Safety Thermometer. (This was a process to collect information

in respect to patient-safety-related to falls, catheters, urinary tract infections, and pressure sores.) Trust wide, safety thermometer findings were in line with the England average rates. Patient safety information was not displayed in clinical areas for patients, visitors or staff to see.

Cleanliness, infection control and hygiene

- All areas appeared visibly clean. Cleaning staff were employed by another organisation; however, staff told us this did not cause any concerns with regards to access or quality.
- No system was in place to indicate when a piece of equipment had been cleaned and was ready for use.
- Antibacterial hand disinfectant was available at the entrances to the wards and departments. It was also present within each birthing and clinic room.
- Staff were seen to be 'bare below the elbows' in clinical areas in accordance with the trust's infection control policy and were observed washing their hands prior to and after carrying out patient care. In addition, staff were observed wearing aprons whilst providing care.
- Aprons and gloves were readily available, and we saw that staff used them when carrying out the specific duties for which they were required.

Environment and equipment

- Stroud Maternity Hospital had one cardiotocograph (CTG) machine for monitoring the fetal heart. This was not used in labour but for women who reported reduced fetal movements. Fetal heart traces could be faxed to the on-call registrar for review at Gloucestershire Royal Hospital.
- There was one ultrasound scanner; however, this was over five years old and as such it was on the medical equipment replacement programme.
- Birthing rooms and bed spaces were equipped with piped oxygen and suction, and two neonatal resuscitaires were available for use in an emergency, one located within the birth suite and one on the ward.
- Birthing rooms were spacious and calming. Birth couches were provided rather than beds, and both main rooms were equipped with pools. In addition, birthing stools, balls and mats were available to facilitate mobility in labour. The rooms had en suite facilities. Emergency evacuation equipment was available for use

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in the event of a maternal collapse in the pool. Transfers out of the pool were practised and manual handling was included in the mandatory training programme for all maternity staff.

- Partners were able to stay with women on the delivery suite, but there were no facilities for them to remain overnight after the birth.
- Equipment was serviced regularly by the trust's maintenance department, which held an inventory of when equipment servicing was due. We reviewed the service dates on a variety of pieces of equipment, including resuscitaires and monitors, which showed these to have been serviced within the last year. Scales had also been calibrated.
- Doors into Stroud Maternity Hospital and also into the ward and birth suite were locked with a buzzer entry system and CCTV. Reception areas were not manned 24 hours per day; receptionist staff gaps were covered by staff on duty.

Medicines

- Not all medicines were securely stored. Medicine cupboards were locked in all areas. However, medicines stored on adult and neonatal emergency resuscitation trolleys were neither securely locked nor stored within tamper-evident drawers/boxes. This meant there was a risk they could be removed or tampered with.
- Staff were aware of the policy for the safe storage, handling and administration of medicines; however, we witnessed one midwife administer a medicine to a patient without checking the patient's identity. Although the midwife had admitted the patient and felt familiar with them, there was a risk of a drug error occurring with this practice. Both the midwife and manager were informed of this at the time.
- There were processes for checking the drug fridge temperatures. We observed that the temperature was recorded daily and fell within acceptable limits.
- Midwives were able to administer some medicines under patient group directives. This included medicines for the emergency treatment of severe bradycardia (low foetal heart rate) in labour and also severe postpartum haemorrhage while transfer to the main obstetric unit occurred. Training for this was included during the midwives' preceptorship programme and included in mandatory training updates.

Records

- During the inspection, we reviewed one set of care records. These contained all relevant risk assessments, such as a risk assessment for the appropriateness of delivery in a stand-alone midwife-led birth centre.
- Women carried their own records for the duration of their pregnancy. Once delivered, women were issued with postnatal records for their care to be documented and a child health record (red book). These were completed by the midwife or midwifery support worker at subsequent visits.
- Access to past medical records was described as good. Medical records for women booked for delivery in Stroud Maternity Hospital and the surrounding areas where a home birth was requested were routinely obtained when the woman was booked for care. Past medical records were also stored for use during consultant-led antenatal clinics for women booked for delivery in the obstetric unit. These could then be accessed by the consultants when they carried out their satellite clinics in Stroud. Once women reached 36 weeks' gestation, records were securely couriered to the main obstetric unit to ensure they were available for labour and delivery.
- Midwives conducted audits of record keeping as part of their annual supervisory review. Their records were audited and reviewed by their supervisor of midwives and any remedial actions identified.

Safeguarding

- Staff received training in safeguarding vulnerable adults and children and recognising abuse. Where appropriate, staff within the maternity service were trained to safeguarding level 3. Across the whole maternity service in the trust, there was an 80% compliance rate. Robust processes were in place for reporting safeguarding concerns, and midwives described the systems. Staff were confident to raise any matters of concern and escalate them as appropriate if they felt no action was taken. Information was available to staff on how to escalate safeguarding concerns, and a quarterly newsletter was produced providing information and updates to staff.
- Systems were in place to identify women and babies at risk, including at risk of domestic violence.

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- The maternity unit employed a lead midwife in safeguarding as well as midwives specialising in substance misuse and teenage pregnancy. These were available to provide support and advice to midwives working in Stroud and the surrounding community.

Mandatory training

- Staff reported good access to mandatory training.
- In addition to trust-wide mandatory training, midwives completed a midwifery mandatory day and also skills drills training. Figures supplied by the trust showed compliance as 82.9%. This was the lowest percentage of all three areas within the maternity service across the trust, with the overall average being 89%.
- Mandatory training also included a 'Prompt' skills drills training day and a one-day maternity update for staff working within the maternity unit. The trust employed practice development midwives, who monitored attendance at mandatory training. Staff were automatically booked onto mandatory training annually. Failure to attend was escalated to managers for action. Attendance was noted to be 93%.

Assessing and responding to patient risk

- All staff used a communication tool known as RSVP, which stood for 'reason, summary, vital signs and plan'. RSVP stickers were seen on telephones and posters were displayed explaining that "effective communication saves lives". Notes we reviewed showed that the RSVP format was followed to assess the patient and develop an onward plan of care.
- Risk assessments were completed for place of birth at booking. This included discussion about the length of time that transfer to the obstetric unit in Gloucester could take. These were reviewed at 36 weeks' gestation and again when the woman was admitted in labour. This ensured the protocol for low risk midwife-led care was followed.
- Where women were identified as being high risk but requested midwife-led care, they were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician. These plans were stored within the woman's notes and also on the supervisor of midwives' shared computer drive to ensure each supervisor of midwives and all band 7 midwives were fully aware of the agreed plan of care. In addition, these were also

emailed to the woman and included in her notes. We spoke with one woman for whom this had occurred. They described feeling fully informed about the risks involved with their decision.

- Staff were able to administer medication to cease contractions in the event of a prolonged foetal bradycardia (low heart rate) and also in the event of a severe postpartum haemorrhage while transfer to the obstetric unit in Gloucester occurred. Women experiencing third and fourth degree perineal tears were also transferred for perineal repair in theatre.

Midwifery staffing

- The funded-midwife-to-births ratio was 1:31.5 across the whole maternity service within the trust. Whilst this had improved from 1:34.1 in October 2014, this was worse than the Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007), which states there should be an average midwife-to-births ratio of 1:28, and also worse than the England average of 1:29. A risk assessment was in place and the risk was monitored via the risk register. Staff described providing one-to-one care for women in labour 100% of the time. One midwife and one midwifery care assistant were on duty for each shift. In addition, one community midwife was allocated to work within the unit in the morning and also in the afternoon. The community midwifery service operated with a further three midwives on call to provide additional cover if required as well as a home birth service. The day prior to the inspection, four women had given birth, each with 100% one-to-one midwifery care.
- Midwifery handovers occurred when staff changed shift at 08.30am and 8.30pm.
- Acuity was monitored using the 'birth rate plus' acuity tool, with acuity monitored four-hourly.
- The service provided a triage service, staffed within the midwifery allocation. On average, 83 women attended the unit for review or care, such as glucose tolerance tests, that would otherwise have required women to travel to Gloucester.
- A clear escalation policy detailed how additional staff were to be obtained in the event of increased sickness or high activity and/or acuity within the maternity

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service. This included additional support from the senior midwifery team and supervisors of midwives. The on-call rota for each of these was evident within the office.

- There were currently no whole-time-equivalent midwifery vacancies across the service. Service-wide midwifery sickness was 3.6% for December 2014.
- The trust had its own bank of midwifery staff; however, short-term staff shortages as result of sickness were covered among the staff currently working in Stroud and the local community. Agency midwives were not used.

Major incident awareness and training

- Staff were aware of processes to follow in the event of a major incident. The trust-wide major incident policy was available to all staff on the intranet.
- A new process was in place to ensure communication of service status across all areas. This had been developed to fall in line with the trust-wide escalation policy. We saw evidence of the current status of the maternity service prominently displayed in staff areas to ensure all staff were aware of it.

Are maternity and gynaecology services effective?

Good



The effectiveness of maternity services were rated as good.

Care and treatment delivered was evidence based, with policies and guidelines developed in line with national guidance. A wide range of pain relief was available including massage, essential oils and water.

The transfer rates to the main obstetric-led unit were reported as marginally below the national average. Staff received training and support to maintain their competence and were supported by the recommended number of supervisors of midwives.

Evidence-based care and treatment

- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. Policies, guidelines and protocols were available for staff to access on the trust's intranet site. However, the service was non-compliant with NICE

clinical guideline 63, on diabetes in pregnancy. There were plans to start undertaking glucose tolerance tests on women with a body mass index (BMI) greater than 30 at booking.

- Policies, protocols and guidelines were subject to review through the service-wide Gloucestershire obstetric guideline group chaired by a practice development midwife, and we observed they were maintained and up to date.
- Babies born with tongue tie were seen in midwife-led clinics. Across the maternity service within the trust, approximately 600 babies were treated annually.
- Regular audits were undertaken, with findings presented monthly. For example, an audit of caesarean section wound infection had occurred. This had resulted in changes to the length of time dressings stayed on, to reduce the risk of infection; details had been communicated to midwives working in the birth centre, as women were able to transfer to Stroud Maternity Hospital for recovery following caesarean section.
- Research had shown the first stage of labour to be shorter for women who were upright or walked around, reducing the likelihood of medical intervention. Midwives in all areas, including Stroud Maternity Hospital, promoted this with the 'Mums Up and Mobile' (MUM) programme.
- Despite being recognised as good practice, there was currently no provision to administer the measles, mumps and rubella (MMR) vaccine to rubella-susceptible women on the postnatal ward. This had been identified as a risk and was on the department risk register.

Pain relief

- Women were encouraged to remain mobile and active during labour to reduce pain. Essential oils were available, and all midwives undertook a half-day study day in their use, with training updates covered within the mandatory study day.
- Nitrous oxide for pain relief was piped into all birthing rooms. In addition, diamorphine was available.
- Women were able to have epidural analgesia only on the delivery suite in the obstetric unit at Gloucestershire Royal Hospital. The birth centre at Stroud Maternity Hospital did not provide epidurals, as it was for women of low risk, requesting normal midwifery care.

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Information about this was provided to women when they chose their place of birth. Transfer to the delivery suite was required if a labouring woman on the birth centre requested an epidural during labour.

- Use of water for pain relief and birthing was promoted, and the number of waterbirths was reported on the service dashboard.

Nutrition and hydration

- The maternity service employed an infant feeding specialist midwife and had achieved UNICEF Baby Friendly Initiative accreditation. All staff underwent initial training in breastfeeding followed by annual updates during the maternity training day.
- The trust-wide breastfeeding induction rate was 75% against a target set by the commissioners of 78%. To support and further promote breastfeeding, all community midwives had a 'breastfeeding toolkit' and lesson plans to ensure consistency of education in the antenatal period.
- Women were supported with their method of choice for infant feeding.
- All babies who had a weight loss of greater than 12% were admitted to the paediatric unit at Gloucestershire Royal Hospital for observation. On discharge, transfer to Stroud Maternity Hospital could occur to continue with the feeding plan and to fully establish confident breastfeeding..

Patient outcomes

- Information relating to outcomes for patients using the service was collated within performance dashboards, although findings for the different maternity services were often reported as findings for the maternity service across the whole trust. All maternity staff received the performance dashboard data monthly via email. In addition, dashboards were presented and monitored within clinical governance meetings and at the divisional board. These fed up into the safety experience review group.
- The maternity performance dashboard for the year 2014/15 showed that between 70% and 75% of all births occurred within the obstetric-led delivery suite at Gloucestershire Royal Hospital. Overall, there were approximately 10–16 home births per month. Staff told

us the largest number of home births took place around the Stroud locality. A trust-wide action plan dated January 2015, entitled 'promoting normality', was on display in the office for all staff to see.

- Transfer rates were reported within the dashboard. Transfer rates of approximately 24.6% were reported from the midwife-led units into the obstetric unit. This was below the national rate of 26.4% as reported in the Birthplace study.
- Year-to-date figures showed across the whole maternity service, 91% of women were booked for antenatal care by 12 weeks and 6 days' gestation, marginally higher than the national target of 90%. (It was noted that on three months, performance had fallen below 90%.)
- Family of origin questionnaires were completed to identify women at higher risk of sickle cell disease and thalassemia. The percentage of these women being screened under 10 weeks' gestation was not reported on the dashboard. Staff told us that following two audits, they had identified that only 33% of high risk women were completing the family of origin questionnaire, and therefore opportunities for early screening undertaken before 10 weeks' gestation were missed. Where possible, women often attended Stroud Maternity Hospital to have blood taken.

Competent staff

- All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training.
- Newly qualified midwives were appointed as band 5 midwives. They then underwent a 23-month preceptorship programme during which they increased their skills and competencies. This included for example, undertaking cannulation, episiotomies and suturing before being eligible to apply to become a band 6 midwife. Newly qualified midwives were not placed to work immediately in the stand-alone unit at Stroud Maternity Hospital .
- There was also a band 6 development programme to support staff to develop into the band 7 role.
- Midwives undertook annual skills drills training in obstetric emergencies such as postpartum haemorrhages, breach deliveries and the management of shoulder dystocia.
- Additional skills and education could be obtained, although it was recognised that funding would not always be available.

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- All midwives were assigned a supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council (NMC) 2012). Supervisors of midwives are referred to for advice, guidance and support. The supervisor of midwives monitors care by meeting each midwife annually (rule 9, NMC, 2012). Other supervisor of midwives roles include auditing midwives' record keeping and investigating any reports of problems or concerns in practice. All the midwives we spoke with had received an annual supervisory review and knew how to contact a supervisor of midwives via the on-call rota.
- Data provided by the trust indicated that supervisory reviews had been conducted within the last 12 months for 81.6% of midwives trust wide. The trust's supervisor-to-midwives ratio was 1:15, which equalled the recommended ratio.
- A supervisor of midwives was on call at all times to support midwifery staff. The supervisor of midwives' rota was evident on the ward and the delivery suite, and midwives described the supervisor of midwives attending when called for support and guidance.

Multidisciplinary working

- Staff described good working relationships and effective communication systems with obstetricians and paediatricians in the maternity unit. Midwives were able to refer directly to these staff if concerns arose.
- There was cohesive working with outside agencies such as social services and the mental health liaison team to promote the safeguarding of mothers and babies.

Seven-day services

- Stroud Maternity Hospital was open seven days a week, 24 hours per day. Midwives provided on-call cover at all times to ensure staffing remained consistent.

Access to information

- Staff had access to medical records. On booking, medical records were obtained for use during the pregnancy. Staff reported no problems with access to medical records.
- Women carried their own pregnancy records, which were provided when booking in. These were used by all clinicians the woman had contact with during her pregnancy. When women moved onto the postnatal

wards or went directly home following delivery, new records were made for use in the postnatal stage. These included all information relating to the pregnancy and delivery and baby. Medical records were created for each baby at birth.

- We observed staff using the RSVP ('reason, summary, vital signs and plan') communication tool when handing over from one to another to ensure effective communication occurred and plans of ongoing care were clear.
- Staff had access to up-to-date policies and guidelines on the trust's intranet site. Changes to key policies were also communicated via the 'maternity and newborn' newsletter and email, for example as new or amended guidance was released from the National Institute for Health and Care Excellence (NICE) or the Royal College of Obstetrics and Gynaecology (RCOG).
- Staff received performance data updates on a monthly basis. This was either emailed or produced in paper format and displayed in ward offices. There had been a recent change in senior staff and, as a result, monthly team meetings had not been held as routinely as previously. We spoke with the new manager, who described plans for monthly meetings to include sharing of updates, performance dashboards and changes in practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records reviewed showed discussions with woman and verbal consent documents. Consent was obtained prior to procedures such as internal examinations and the management of the third stage of labour.
- During the inspection no patients were subject to a deprivation of liberty application.

Are maternity and gynaecology services caring?

Good



Caring within the maternity services was rated as good.

Care was seen to be delivered with kindness and compassion. Women were involved in decision making, and staff ensured understanding and involvement of

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patients and their partners/relatives and emotional support through good communication. Patients and their relatives had a good understanding and described feeling involved in the care.

Compassionate care

- We observed care being delivered with kindness and compassion by staff at all levels.
- One woman told us “it’s amazing here,” and another that “the calmness makes such a difference here”. People we spoke with described feeling well looked after, for example being brought hot chocolate to drink during the night when the baby was unsettled, and the ability of partners to access hot drinks whenever they wanted.
- Staff were encouraged to promote the Friends and Family Test; however, collected responses were not displayed for members of the public to view, nor were they included on the maternity dashboard.
- Results from the CQC survey of women’s experiences of maternity services (2013) reported outcomes for the trust about the same as for other trusts, with three questions scoring higher than most trusts. These all related to care during labour and birth, and were ‘being spoken to in a way you could understand’, ‘being involved enough in decisions about care’ and ‘being treated with respect and dignity’. The CQC survey did not differentiate between each unit in the trust.

Understanding and involvement of patients and those close to them

- Staff were observed explaining procedures and involving patients and their relatives in decision making. We observed staff explaining an examination of the newborn to new parents, giving time for questions and answering any concerns raised.
- Within the maternity service, women were supported in their choices through clear discussions of the risks associated with their choices, which were documented, for example when electing to deliver at home despite being deemed high risk.
- Staff were seen providing reassurance and explanations to partners and relatives. Relatives described feeling included and involved in the care of their partners.

Emotional support

- Women requiring transfer into the delivery suite at Gloucestershire Royal Hospital from home or the

maternity unit were accompanied by the midwife who had been providing their care. This midwife remained present until care had been handed over, remaining as their ‘familiar face’ and continuing to provide emotional support.

- Women were able to transfer to the maternity unit for ongoing postnatal care, even if delivery occurred elsewhere. We spoke with one woman who had delivered in another trust but had chosen to transfer to the maternity unit before being discharged home, in order that she could recover and get the support needed to firmly establish breastfeeding.

Are maternity and gynaecology services responsive?

Good



Maternity services were responsive.

Women were supported to make choices about where to have their babies. The service provided from Stroud Maternity Hospital supported home births as well as births in the maternity unit. Women requesting or requiring obstetric care were referred to the main obstetric unit at Gloucestershire Royal Hospital, and women delivering elsewhere were able to transfer to the maternity unit to recover and establish feeding postnatally. Counselling services were available for women who had experienced traumatic deliveries.

Translation services were available, although there was a delay in accessing information leaflets in other languages.

Service planning and delivery to meet the needs of local people

- Most routine antenatal care was carried out by community-based midwives. Women were able to attend the maternity unit for antenatal care, and a triage service reviewed approximately 83 women per month. Outreach consultant-led antenatal clinics were held weekly to allow women to be seen nearer to home.
- The maternity service dashboard for 2014/15 reported that the trusts maternity units had not been required to close and the home birth service had not needed to be suspended.

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- Staff were able to refer women to the 'let's talk service', a counselling service for women who had previously experienced a traumatic delivery. Sessions were provided within the maternity unit by a visiting counsellor.
- One midwife was trained in baby massage. Sessions were held in the conservatory at Stroud Maternity Hospital for mothers and babies up to six months old. In addition, yoga sessions were held, which were funded through charitable funds.
- The conservatory was also used to hold parentcraft sessions and tours weekly, which staff felt helped to promote the maternity unit as an option for place of delivery.

Access and flow

- Three community midwives were always on call at any one time to provide additional midwifery support to the maternity unit during peaks in activity.
- Midwives were trained to undertake the newborn screening examination. This meant babies could be screened in the maternity unit prior to discharge, without the need to be seen by a medical practitioner.
- Discharge information was communicated to GPs and community midwives when women were discharged from the maternity unit. Discharge summaries were written and sent to GPs to ensure they were aware of the care and treatment given.

Meeting people's individual needs

- Translation services were provided by a telephone translation service. Leaflets were available in alternative languages, although these were not immediately available for midwives to give women, but had to be ordered in.
- Women were able to transfer to the maternity unit postnatally to recover and establish feeding, even if they had delivered in another trust. We spoke with one woman who had elected to do this and was delighted with her choice.

Learning from complaints and concerns

- The number of complaints received was monitored on the service dashboard. Complaints were processed centrally and sent to the lead for investigation and the formation of a response.

Are maternity and gynaecology services well-led?

Good



The maternity and gynaecological services were well led.

The service had a well-defined governance structure with a good connection to the board. Activity, quality and risk was monitored and reported on; however, actions to address risks were not recorded on the risk register. Specialist midwives were employed to support the governance function.

The women's and children's divisional management team had been stable since 2006. Staff were positive about the support from senior staff and immediate managers. Staff described an open culture that encouraged honesty. There was good patient and public engagement.

Staff actively promoted the Mums Up and Mobile (MUM) project to promote normality in labour. Through supervision, women were supported with their birth choices.

Vision and strategy for this service

- There was a clear vision for the maternity unit, which centred around the promotion of normality in labour. Staff we spoke with were clear on that and the provision of women-centred care.

Governance, risk management and quality measurement

- There were clear governance processes that fed into the women's and children's division. The maternity unit reported and participated in service-wide meetings that oversaw activity, performance, quality, safety, audit and risk. These in turn fed into the division and on into sub-committees of the board. There was divisional representation on these committees. Specialist midwives were employed to support the governance function of the service.
- Practice was reviewed and learning shared, for example following a serious incident involving cardiotocograph (CTG) monitoring in another area of the maternity service.
- We reviewed the service-wide risk register. This contained a description of the risks, the date they were

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added to the risk register and the date they were due for review. The service was in the process of migrating risks from one electronic system onto another. Risk assessments were reviewed and each demonstrated actions put in place to mitigate the risk. The highest risks identified on the risk register were staffing, the ageing scanning equipment and, following a trust-wide change in mobile telephone service providers, poor coverage, contact and communication within the community. We saw from meeting minutes that this had been reported divisionally and trust wide and changes were about to be implemented to improve overall coverage. Staff told us they would escalate risks identified to their managers for inclusion in the risk register.

Leadership of service

- Lead midwives were described as visible, approachable and supportive. All staff we spoke with were positive about the support they received from the senior staff and immediate managers, and teams were described as cohesive and supportive.
- The women's and children's divisional management team had worked together in that capacity since 2006. They described a supportive team around them that allowed them to function well.

Culture within the service

- There was an open and positive culture across all the maternity services within the trust promoted loyalty and teamwork among the midwives.
- Staff described feeling supported to raise concerns.
- The opening of the main maternity unit in 2010 had seen the bringing together of two smaller obstetric-led

units successfully into one. In 2011, Stroud Maternity Hospital was added into the service. Staff described holding a ball to encourage teambuilding and integration. This had proved to be a huge success, and staff felt it had been key in bringing the two teams together. As a result, the maternity service continued either to hold a ball or put on a review each year. The next ball was planned for May 2015.

Public and staff engagement

- The maternity service had lay-user representation within a number of groups. There was also a trust Facebook page with links to the maternity service.
- Following a threat to close Stroud Hospital and the Maternity Unit some years ago, a support group was formed. Known as 'Maternity Matters' it remained active in supporting and promoting the maternity services and providing additional funds. The unit had a large conservatory that had been part-funded by the group.
- Staff were asked to provide ideas for improvement through the 'maternity and newborn' newsletter that was circulated to all areas. The newsletter detailed actions that had occurred as a result of staff feedback. For example, skills drills were now held in the birth centre in Gloucestershire Royal Hospital as well as on the delivery suite following requests for training to be focused in the normal setting as well as the high risk care setting.

Innovation, improvement and sustainability

- Staff actively promoted the Mums Up and Mobile (MUM) project, which had also been presented nationally at midwifery conferences. Through supervision, women were supported with their birth choices.

Outstanding practice and areas for improvement

Outstanding practice

- Staff actively promoted the Mums Up and Mobile (MUM) project, which had also been presented nationally at midwifery conferences. Through supervision, women were supported with their birth choices.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure all staff are trained in the safe storage, handling and administration of medicines.
- Ensure systems are in place so staff know when equipment has been cleaned and is ready for use.
- Review the processes to ensure early screening (pre 10 weeks' gestation) can occur where indicated.
- Review the storage of emergency drugs to ensure they are accessible but safely stored, checked and tamper-evident.
- Review the timeliness of access to patient information in alternative languages.