Shrewsbury and Telford Hospital NHS Trust

# Oswestry Maternity Unit

## Quality Report

Robert Jones & Agnes Hunt Hospital
Gobowen
Oswestry
Shropshire
SY10 7AG
Tel: 01691 404000
Website: www.sath.nhs.uk

Date of inspection visit: 1 November 2016
Date of publication: 16/08/2017

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Good |
| Maternity and gynaecology | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected Oswestry Midwife Led Unit as part of a focused inspection of Shrewsbury and Telford Hospital NHS Trust in November and December 2016. We visited the unit unannounced on 1 November 2016.

We rated Oswestry Midwife Led Unit as good overall.

- Staff fully understood their professional responsibility to report incidents and concerns. No serious incidents had been reported between 01 November 2015 and 31 October 2016
- Patient records were stored securely and we saw they were up to date and legible.
- 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, ensuring that effective care and treatment could be delivered.
- Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate
- 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
- Midwives were clear about their role and levels of accountability

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Maternity and gynaecology | Good | Staff understood their responsibility to report incidents and concerns. No serious incidents had been reported between 01 November 2015 and 31 October 2016<br>Patient records were stored securely and we saw they were up to date and legible. Care and treatment is delivered in line the current evidence based guidelines.<br>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.<br>Effective systems of communication were established between the consultant led unit and the MLU, ensuring that effective care and treatment could be delivered.<br>Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate.<br>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. Midwives were clear about their role and levels of accountability.<br>We found urine sample bottles were stored in public toilet, this did not reflect safe practice. When we brought this to the attention of the manager the bottles were removed immediately along with urine testing strips and disposable receivers. |

# Oswestry Maternity Unit

## Detailed findings

**Services we looked at**
Maternity and gynaecology

# Detailed findings

## Contents



## Background to Oswestry Maternity Unit

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

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

The maternity unit is part of the Royal Shrewsbury Hospital NHS Trust based within the Robert Jones and Agnes Hunt Orthopaedic Hospital, Gobowen; a low-risk unit offers labour, delivery and postnatal care in a small homely environment.

The midwifery-led unit (MLU) at Oswestry had 163 admissions with 62 deliveries between 01 November 2015 and 31 October 2016.

We inspected this unit as part of our unannounced midwifery service inspection.

## Our inspection team

Our inspection team was led by:

**Inspection Manager:** Debbie Widdowson, Care Quality Commission

The team included a CQC inspector.

## How we carried out this inspection

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

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

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

# Detailed findings

This was a focused inspection, following up our inspection from 2014. The unit was rated as good in all domains.

## Facts and data about Oswestry Maternity Unit

The MLU at Oswestry had 163 admissions between 01 November 2015 and 31 October 2016 with the average length of stay 1.99 days. In the same time period there was 39 transfers out to The Princess Royal consultant led unit; the main reason for transfer were recorded as delays in labour and fetal concerns.

## Our ratings for this hospital

Our ratings for this hospital are:

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

# Maternity and gynaecology

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

## Information about the service

The Oswestry midwifery-led unit (MLU) is based within the grounds of Robert Jones and Agnes Hunt NHS Trust. The unit has two labour rooms, one with a pool, and a five-bed bay for antenatal and postnatal care. Shared toilet and shower facilities were available for women during their stay.

The unit offers a friendly 'home-from-home' atmosphere with an emphasis on natural birth The MLU admits women who have been assessed as low risk and suitable to deliver their baby there, as there are no medical facilities. Women who book and attend to deliver their baby in the MLU would be transferred to the consultant led unit at Princess Royal Hospital, 34 miles away during labour when complications arose. Between November 2015 and October 2016 there were 163 admissions and 62 births in the unit and 275 births within the community midwife area.

The MLU also 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.

The unit is staffed by a team of midwives and women services assistants (WSA), who also offer a community midwifery service to the local area. We did not specifically inspect the community midwifery service during this inspection. One midwife, with a WSA was 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 office hours.

GP clinics were held at the unit each day. A midwife sonographer held a clinic in the unit weekly and a consultant held a clinic at the unit every other week. On the day of the inspection, there were three women and three babies in the unit.  We spoke with five members of staff, two women and we reviewed two sets of patient notes.

# Maternity and gynaecology

## Summary of findings

We rated this service as good because:

- Staff understood their responsibility to report incidents and concerns. No serious incidents had been reported between 01 November 2015 and 31 October 2016
- Patient records were stored securely and we saw they were up to date and legible.
- 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, ensuring that effective care and treatment could be delivered.
- Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate
- 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
- Midwives were clear about their role and levels of accountability

However:

- We found urine sample bottles were stored in public toilet, this did not reflect safe practice. When we brought this to the attention of the manager the bottles were removed immediately along with urine testing strips and disposable receivers.
- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.

## Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- Staff understood their responsibility to report incidents and concerns. No serious incidents had been reported between 01 November 2015 and 31 October 2016.
- Systems were in place to minimise the likelihood of infection and we observed that Oswestry MLU appeared visibly clean in all areas we inspected.
- Medicines were managed safely; controlled drugs were checked and signed as correct at the beginning of each shift.
- Patient records were stored securely and we saw they were up to date and legible.
- All staff had received safeguarding training and there were systems in place to ensure prompt referral of safeguarding concerns were made.
- Formal handovers took place at the beginning and end of each 12 hour shift. Women's care was discussed and their plan was reviewed.

However:

- We found urine sample bottles were stored in public toilet, this did not reflect safe practice. When we brought this to the attention of the manager the bottles were removed immediately along with urine testing strips and disposable receivers.
- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.

**Incidents**

- Staff fully understood their professional responsibility to report incidents and concerns and were encouraged by managers to do so. Staff were knowledgeable about what constituted a serious incident and they were able to describe the types of situations they would expect to report. Staff told us that incidents and complaints were discussed and reflected at ward meetings through the 'quality and safety report'; this ensured the information was reached all staff to ensure lessons were learnt.
- 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 39 women transferred to the consultant led unit between 1 November 2015 and 31 October 2016. If the service is not reporting all transfers as incidents an opportunity to learn from these events may be missed.

- Incidents were reported by staff through the trust's electronic process and feedback was received from the manager. There was also a "tick box" for staff to complete on the electronic form to request feedback. We were told that incidents and complaints were discussed at monthly ward meetings through the 'quality and safety report'; this ensured the information was disseminated to all areas and to promote cross unit learning. Midwives were able to describe incidents that had occurred within the service.
- No serious incidents had been reported between 01 January 2015 and 31 December 2016. There were 37 incidents reported. Twenty six no harm incidents and nine low harm incidents reported during this timescale.
- 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
- There was evidence that staff from the MLU did not attend the monthly perinatal mortality meeting. However, the manager received the minutes and shared the information with the staff.

**Duty of Candour**

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person
- Staff we spoke with described their obligations under duty of candour (DoC) and were aware of when they would be required to act upon this. They had not participated in specific training that focussed on this but told us they had received information and could find further guidance. There had been no incidents, which required doc investigation.
- We heard examples whereby the trust had supported midwives being open and transparent through the Duty of Candour process and a 'no blame' culture.

**Maternity safety thermometer**

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

**Cleanliness, infection control and hygiene**

- We observed that Oswestry MLU appeared visibly clean in all areas we inspected. Cleaning schedules were signed and appropriate equipment was in place such as foot operated bins.
- We observed all staff complying with the trust infection control policy. We saw staff regularly washed their hands and used hand gel. The hospital's 'bare below the elbow' policy was adhered to. The October 2016 hand hygiene audit report showed 100% compliance had been achieved.
- 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.
- Infection control guidelines, protocols and procedures were readily available on the intranet.
- We reviewed the birth pool and found this to be well maintained with a daily signed cleaning schedule. Staff were knowledgeable of the procedure to clean the birth

pool and the contradictions for use. Water samples were taken from the pool as per the Legionella policy and the water system was run twice a week. Thermometers were used for water temperature testing prior to the women entering the pool and a thermometer remained in the pool during use.

**Environment and equipment**

- The staff told us that they had sufficient equipment to confirm the health and well-being of mothers and babies. We saw that equipment was suitably maintained and regularly tested. In the event of equipment being faulty, it was replaced or repaired promptly by the estates team.
- The resuscitation equipment, including a resuscitaire for babies was accessible in an emergency situation. Signed records demonstrated that the equipment was checked daily and portable appliance testing was in date.
- Store cupboards were locked and found to be clean and tidy, when opened.
- A new-born transfer pod was stored on the ward. This was checked and signed as in order daily by the women's service assistant (WSA).
- The Ultrasonography midwife explained the process for servicing and testing the scanner. A call bell was available in the scanning room should the need to alert other staff be necessary.
- The homebirth equipment carried by community midwives was checked and re stocked on the unit after each home birth or every Sunday. Community bags were currently part of an audit to standardise the equipment bag.
- Fetal heart monitors and blood pressure cuffs were cleaned and checked after each use.
- In the waiting area public toilet, we found urine sample bottles and swabs stored on a radiator. Some urine specimen bottles contained boric acid preservative. Boric acid helps to maintain the microbiological quality of the specimen during transport to the laboratory. Although boric acid is only poisonous if taken internally or inhaled in large quantities, its storage in this location was a risk as it was accessible to children. These items were removed immediately along with urine testing strips and disposable receivers.

**Medicines**

- We observed that all medication was stored appropriately on the unit.
- One medication refrigerator had recently been under investigation and the contents destroyed due to variances in the temperatures being recorded. The estates department were currently running tests on the item to establish whether it was for repair or replacement.
- The staff we spoke with told us that there were no issues in obtaining pain relief during labour.
- A medication audit carried out in October 2016 showed the unit was compliant with good practice guidelines. Three issues were identified which related to room thermometer calibration, the pin code key lock to medication room had not been changed recently and intravenous fluids were found on a birthing room trolley. All these issues had been addressed when we inspected.
- Patient Group Directives (PGD's) were in place on the unit. PGD's ensure patients receive safe and appropriate care and timely access to medicines, in line with legislation.
- To take out (TTO) medication was arranged on transfer, or faxed from the consultant led unit.
- The women we spoke with told us that they had not received any medication whilst on the unit.
- 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 carried out October 2016 scored 100% . One query was raised within the audit which related to two midwives being required but not always being available to check controlled drugs. This issue was resolved with the community midwifes attending the unit.

**Records**

- Patient paper records were stored securely in an office trolley.
- Women were issued with a copy of their care plan, which they retained throughout their pregnancy.
- We reviewed two patient records and found them to hold relevant clinical information including risk assessments, which was legible, signed and dated in accordance with guidelines.
- The trust conducted a records audit in November 2016. Forty five records from maternity service were reviewed including five sets of patient records from Oswestry MLU. The results showed that records were appropriately kept. Improvements were required with ensuring the

patient's name and unit number were consistently used and entries were in chronological order. There was also a recommendation to review storage arrangements for assessment and investigation records.

**Safeguarding**

- The staff we spoke with told us they followed safeguarding maternity guidelines and had attended safeguarding training. The unit attendance at safeguarding training was recorded as Level 2 100% for adults and children and Level 3 88% with further dates for attendance in the diary.
- Support plans were put into place to support women with additional needs including referral to the Supporting Women with Additional Needs (SWAN) team. This team visited the unit to ensure their needs and requirements were being met.
- Staff we spoke to were able to confidently described situations, which would prompt a safeguarding concern and lead to a referral being made. Staff told us they would contact the lead midwife for safeguarding within the trust or if 'out of hours' the social worker would be contacted with a faxed referral completed following the telephone call.
- A new-born standard operating practice (SOP) was in place for review in May 2018. This stated that the new-born infant should be cared for in a secure environment to which access is restricted and a reliable baby security system enforced, to minimise both clinical and non-clinical risk issues for the most vulnerable.
- Women were given the opportunity to raise any concerns, confidentially with the midwife during clinic appointments or by contacting them by telephone. No safeguard referrals had been made during this reporting period.
- 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**

- We saw the maternity-specific mandatory training guideline, which included the training needs analysis for 2016-2019. This detailed what was required for midwives, women's support assistants and medical staff and how often. There were 35 modules in total and included appropriate modules such as obstetric emergency multi-disciplinary skills drills, a fetal monitoring package, newborn life support skills, early recognition of the severely ill woman, post-operative recovery skills and neonatal stabilisation. Compliance rates for all modules were provided at service level only and not 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%. During the inspection, we were told by leaders at Oswestry that the compliance rate at the unit was 100%. 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 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 Oswestry this was completed during a 'three day' annual mandatory training programme. Trust mandatory training competition target was 100%.

**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.
- When a woman reached 36 weeks of pregnancy, a final decision on the place of delivery was made. Decisions were made involving midwives at the MLU and the woman. Only women categorised as low risk were able to deliver their baby at the MLU or their own home. Those with additional risks would be advised to deliver their baby at the consultant led unit.
- 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.

- Early warning scores were recorded daily to monitor any potential deterioration in a woman and new-born's condition. The Modified Early Obstetric Warning Score (MEOWS) and National Early warning Score (NEWS) was recorded to detect the need for early intervention or transfer of a woman or new born.
- The new-born's NnEWS score was recorded at delivery and subsequently monitored for several hours following the birth. Speaking with the midwife it was clear that they had the knowledge, skills and experience to appropriately escalate any concerns to the head of midwifery or on call doctor. We were told that with no hesitation when any new-born infant triggered increased assessment scores they would dial 999 to ensure early transfer to the consultant led ward. We saw these early warning score records were dated and signed.
- We saw the trust's perinatal sepsis guideline 'Sepsis related to the antenatal, intrapartum and postnatal period' due for review in September 2016. This included the nationally recognised 'Sepsis 6' care bundle and the maternity sepsis screening tool, in line with Sepsis Trust UK guidance.
- There was a policy and procedure in place for transfer of deteriorating patients. Midwifes followed the trust policy for the transfer of women in labour to the main site including the management of women or babies who showed signs of deterioration and required additional care. Women were transferred by ambulance from the MLU to the consultant led unit at Princess Royal Hospital with a telephone call made to inform the receiving unit. Staff told us that the process worked well and that they were well supported by the consultant unit in these situations.
- The trust told us it does not currently audit the transfer of women from the consultant unit to the MLU as this is part of the planned process, however, they are planning an audit of handover of care between the CLU and the MLU during 2017/2018 as part of their audit programme.
- Between 01 November 2015 and 31 October 2016 there were 39 transfers out of the MLU to the consultant led unit at Princess Royal Hospital. The main reason for transfer were recorded as delays in labour and fetal concerns.
- We were told that the medical staff from Princess Royal Hospital were supportive and available at all times over the telephone for advice and guidance. Scans and fetal measurements could be faxed to the consultant led unit for review and second opinions.
- A service-wide review of transfers by ambulance to the CLU between April and September 2015 included data from five women transferred from Oswestry. The review concluded that women were not being unnecessarily transferred and outcomes for those who were transferred were good.
- A birthing pool evacuation policy was in place, including manual handling guidance for care of the women. Each woman was risk assessed to use the pool prior to being included in the birthing plan. The staff practiced 'skills and drills' for the emergency removal of the women from the pool should their blood pressure drop or the delivery process change. The WSA explained how the pool was filled higher to remove the women with the support of a handling net and how the fast drain system emptied the water.
- 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 146 women transferred for post-natal care between 1 November 2015 and 31 October 2016.

**Midwifery staffing**

- The planned staffing levels were a minimum of one midwife on the unit at all times. On Mondays and Thursdays an extra midwife was rostered on to the unit to undertake clinics duties. An Ultrasonography midwife held a weekly scanning clinic.
- Staffing levels were displayed on the unit and we saw that the MLU was continually staffed with one midwife and one WSA. There were 10 staff employed on the unit.
- One community midwife was on duty covering the Market Drayton and Whitchurch areas, working 7 and a half hours; they would attend the unit as necessary to provide support during the day. An on call midwife

supported the night staff. When a home birth was planned, there would be two midwives on call for the duration required. 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.

- Midwives from Oswestry told us they were not called in to help out at the consultant led unit in Telford.
- Staff told us they did feel pressured at time, and working hours may be longer than scheduled, but as a team worked well together. The on call process did present problems when the midwife was rostered to work the next day and had been on visits during the night. The team were flexible in supporting each other with swapping on calls to ensure sufficient rest was gained. This process was led by goodwill and not a formal arrangement.
- The unit did not use agency midwives, where there were staffing shortages, cover was arranged internally through extra shifts for permanent staff or bank staff.
- There were no staff vacancies and there was no staff on long-term sick leave. The manager told us that there was a waiting list of midwifes who had requested to work on the unit.
- Staff told us that women received one-to-one care in labour and there were always two midwives present at delivery. An on call system was in place for the time around the due date in order to facilitate this. Staff worked 12-hour shifts to cover these requirements. In addition to this, one midwife was on call during the night in preparation of being called to assist with the second stage of labour when necessary.
- Formal handovers took place at the beginning and end of each 12-hour shift. Each woman was discussed and her care was reviewed.
- Post-natal checks were carried out in the community, however the community midwife arranged with those women who were able, to attend the unit; this avoided them waiting in all day and assisted with the community workload.
- Student nurses and midwives were allocated to the unit as part of their training. We spoke with a student midwife from Staffordshire University who told us they had felt welcomed and on completion of their induction they were included in the MLU activity.

**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.
- We were told by staff that the medical support during the day, at weekends and during the night was very responsive. Transfers for review were arranged as necessary without question.
- We were told that telephone conversations with medical staff were documented to evidence review of the woman when their condition changed.

**Major incident awareness and training**

- Fire safety awareness training was included as part of the staff mandatory training course.
- Situated on the Robert Jones & Agnes Hunt Hospital site the unit had not heard about any incidents or security issues from the site managers.
- The trust had a major incident and business continuity plan should the need arise. The MLU could be used if issues within the midwifery beds occurred.
- Staff told us that they adhered to the lone worker policy which was in place and accessible on the trust intranet. When working in the community, midwives would take their own mobile telephone as well as the unit phone; with a list of the addresses where they were going available on the unit. This meant that if staff at the unit were concerned about them or if they did not return when expected they would try to contact them. On occasions when difficult situations had arisen, the police had escorted the midwives in the community.

## 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), 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, ensuring that effective care and treatment could be delivered.

- Pain relief was discussed with women and administered in line with their birth plan where possible
- There was an effective approach to supporting staff; continual professional development and learning opportunities were promoted
- Verbal consent was gained between the mother and midwife during examinations and the recording of observations

**Evidence-based care and treatment**

- 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 medium and low risk women, who chose to give birth at home or in a MLU, received safe, evidenced-based care. The service audited compliance with NICE guidelines on an annual basis.
- In line with NICE Quality Standard 22, antenatal care included screening tests for complications of pregnancy and the antenatal care of all pregnant women up to 42weeks of pregnancy. This included primary, community and hospital-based care.
- 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 particular requirements for antenatal care in line with Royal College of Obstetricians and Gynaecologists 2008 guidelines (RCOG 2008).
- Effective systems of communication were established, between all team members and each discipline, as well as with the women and their families and was in line with **RCOG** 2008.
- Trust wide policies and procedures were available on the intranet with key documents printed off as required.
- Maternity 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.
- The results showed that for most of the areas the trust achieved above 90%; mothers stated they had received adequate support. The percentage of babies provided with supplements to breastmilk should be below 20% however the trust had supplemented 24%.The score for mother's being shown how to hand express breast milk only just passed with a score of 81%.

**Pain relief**

- Women we spoke with confirmed that their pain had been well managed and in line with their request.
- A variety of pain relief sources was available to women including tablets, injections and gases such as Entonox. A birth pool was available for women to choose water emersion for pain relief in labour.
- Staff told us that pain relief was discussed with women and administered in line with their birth plan where possible.

**Nutrition and hydration**

- The women we spoke with were satisfied that they had received adequate meals and hydration. There was a choice of hot and cold drinks and meals were ordered from a menu system. Women could walk to the restaurant in the main hospital if the wished.
- 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. A lactation consultant was available to support women and offer advice to the midwives when breast feeding was not possible.

**Patient outcomes**

- In 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030, with a 20% reduction by 2020. The trust had recently 'signed up to safety' to contribute to the NHS England ambition to improve maternity outcomes.
- The midwife to birth ratio for the trust from April to November 2016 was 1:30 and was in line with the recommended target of 'Birth-rate Plus'. The data provided was trust-wide and not broken down by unit. We were unable to determine the midwife to birth ratio for the MLUs.

- The trust wide percentage of women having their babies at home was 1.3% as of November 2016 and this was the percentage for 2015/16 overall. This was just below the national England average for home births of around 2%.
- Maternal smoking status at the time of delivery data showed that the trust had a rate of 16% from April to November 2016 and 15% for 2015/16, which was better than the locally agreed target of 20%.
- A trust wide audit was conducted involving 43 mothers who were interviewed about the breastfeeding support they had received while under their care. Questions included the support provided by staff at birth, learning about breastfeeding, food and fluids provided other than breastmilk, relationship building between mother and baby and antenatal care. The results showed that for most of the areas the trust achieved above 90%; mothers stated they had received adequate support. The percentage of babies provided with supplements to breastmilk should be below 20% however the trust had supplemented 24%.The score for mother's being shown how to hand express breast milk only just passed with a score of 81%.
- During 2016, the service introduced a maternity dashboard that identified performance and key patient outcomes benchmarked against the RCOG maternity dashboard. Oswestry MLU demonstrated 100% normal delivery which was better than the local target of 85%, less than 4% manual removal of placenta, which was above the expected range of 0-2% and less than 4% third or fourth degree tears reported, which was within the expected range of 0-5%
- Zero stillbirths were reported for this unit.
- There was two maternity readmission between September 2015 and August 2016. One admission in January 2016 and one in February 2016.

**Competent staff**

- The service has a policy and procedure in place that set out the process for rotation of midwives in order to assist in supporting staff to gain experience in key areas of Midwifery and to refresh skills. A list of those rotating is produced every April and October. The service undertook a survey of midwives in May 2016, of the 213 respondents across all areas, 70% of midwives said they thought their clinical practice was enhanced.
- 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.
- To support women attending the ward, one midwife had secured a place on a hypnobirthing course. Women could opt for hypnobirthing at the unit. Hypnobirth is a term used to describe the use of hypnotherapy techniques to relax the mother-to-be during labour and birth. In line with the birthing process, there are two phases to the hypnobirthing process, preparation and delivery.
- Trust guidelines and policy updates were discussed during staff meetings including future models of care to ensure staff are kept up to date and any training needs are identified.
- 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.
- Current appraisal rate was 79% with 15 of the 19 staff having received their appraisal. The remainder of the staff were planned to be completed within the annual appraisal programme.
- Staff told us they attended continual professional development and learning opportunities which were fully supported by the ward manager. Arrangements to change how current clinical supervision was delivered were in the discussion stage along with supervisor of midwives changing role.
- There was a structured induction programme for new members of staff to work through. All new staff were required completed an induction booklet, which was signed off by the ward manager.

**Multidisciplinary working**

- The staff described robust multidisciplinary working that was effective. Good communication and links with local GP's ensured the women had the support they required when discharged.
- Staff described a good working relationship with all staff in the trust. When staff at the MLU had any concerns during antenatal checks they would contact the early pregnancy unit or labour ward at Princess Royal

Hospital to review the information with a senior midwife or medical staff. They described a positive working relationship and could refer women to be seen and arrange urgent scans when necessary.
- The maternity service promoted multidisciplinary team working, including antenatal services. Community midwives, health visitors and social services staff promoted joint working.
- Daily communication with the community maternity team ensured good working relationships were maintained between all the staff.

**Seven-day services**

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

**Access to information**

- The trust record management system ensured that the staff had the appropriate access to relevant notes to assist them with care of the women and their babies.
- Staff had access to up-to-date policies, procedures and treatment guidelines via the trust's intranet. This system was accessible and staff were able to show us where to find policies and protocols as well as trust wide updates.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Staff told us they provided as much information as possible before gaining consent. Verbal consent was gained between the woman and midwife during examinations and the recording of observations. This was confirmed by the women we spoke to and the records we looked at. Staff showed good awareness of the procedure to follow regarding the Mental Capacity Act and the importance of informed consent.
- One deprivation of liberty safeguard was reported by midwives in the unit between 01 November 2015 and 31 October 2016.

## Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Results of the NHS friends and family survey showed that the proportion of women who would recommend the service was better than the England average.
- Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate
- We were told that women were monitored for their wellbeing at all stages of the pregnancy and following the birth. Assessments for anxiety and depression were recorded throughout their care.
- When necessary counselling services were arranged through discussion with the women, the GP and the midwife to provide emotional support where needed.

**Compassionate care**

- The trust participated in the NHS Friends and Family survey. Between August 2015 and August 2016, the results for the antenatal care survey showed that the proportion of women who would recommend the service was better or similar to the England average for the same period. This was also the case for the birth, postnatal ward and postnatal community survey results.
- For August 2016, the trust's performance for antenatal was 96%, for birth was 100%, for postnatal ward was 99% and for postnatal community was 100%.
- We observed staff interacting with women in their care in a caring and compassionate manner.
- Women we met on the ward told us that they felt very well cared for and the staff were caring, thoughtful and compassionate.
- The staff on the ward had received many thank you cards and letters of appreciation. .

**Understanding and involvement of patients and those close to them**

- Women on the ward told us they had been fully involved with their care plan and felt very well supported by all the unit staff.
- We were told that the partners were also encouraged to be involved during the delivery and following the birth.
- We heard from women that additional support was offered when required and they were encouraged to ring in to the unit with any queries.

# Maternity and gynaecology

### Emotional support

- Staff told us were told that women were monitored for their wellbeing at all stages of the pregnancy and following the birth.
- We were told that assessments for anxiety and depression were recorded throughout their care. At 16 weeks post-delivery, the midwives discussed their general feelings regarding mental health and assessed the need for further support.
- The supervisor of midwives was debriefed about any women in the unit or the community, when their mental health had raised concern.
- Bereavement counselling was available for staff to refer women to if they required following the loss of a baby.
- When necessary counselling services were arranged through discussion with the women, the GP and the midwife.
- Occupational health support was available for midwives and unit staff requiring emotional support.

## Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Systems were in place to ensure the service was meeting the individual needs of women using the service. For example, a five week parent craft course was held at the GP Clinic, with a monthly, condensed course, held at the MLU on Saturdays; enabling both parents to attend where possible
- In the CQC Maternity survey 2015 the trust performed better than others for patients feeling their length of stay in hospital was appropriate
- Staff were aware of the information women would require if they wanted to make a complaint and were clear of the procedure.

### Service planning and delivery to meet the needs of local people

- The MLU promoted a 'home from home' experience where partners were made welcome and could access facilities as well as the women. Partners had open visiting to the unit.
- There were 62 births at Oswestry MLU. Midwives based at the unit also provided community care to the local area; there were 275 births within the community midwife area during the reporting period. There were 163 admissions to the MLU, which included women who had chosen to give birth at the unit but were transferred to the consultant unit and those who chose to receive postnatal care at the unit.
- Anti-natal clinic appointments, held at the unit, were scheduled to meet the needs of the families; drop in sessions were promoted to reassure women if they felt reduced movements or wished to hear the fetal heartbeat.
- Tours of the unit were arranged during the anti-natal appointments for the women and their birth partner.
- A five week parent craft course was held at a GP Clinic, with a monthly, condensed course, held at the MLU on Saturdays to allow both parents to attend where possible. Individual parent craft sessions were arranged when women required further support.

### Access and flow

- Women could access the maternity services for antenatal care via their GP or by contacting the community midwives directly.
- 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.
- In the CQC Maternity survey, 2015 the trust performed better than others for patients feeling their length of stay in hospital was appropriate.
- Admissions in to the unit were planned following the initial risk assessment at the first booking appointment. Re-admissions were booked through the consultant led unit or the GP.
- Community midwives also re-admitted women when they identified that increased support would be beneficial to the women and new-born.
- Women we spoke with were aware of when they were potentially due to go home. Discharge information was issued to women with advice and guidance notes.
- Post-natal follow up care was arranged as part of the discharge process with community midwives.

### Meeting people's individual needs

- Women who were cared for on the MLU told us that they were given a choice following a thorough and continuing risk assessment process. They fully understood they were required to follow the advice of the midwives in line with the trust guidelines.
- Information leaflets were available for women to take from the unit offering pregnancy advice and guidance.
- Women requiring extra support were visited by the SWAN midwife. They were able to advice and guide women who required physical, financial or mental health support.
- Women with learning disabilities were supported on the unit; their carer was encouraged to remain with them at all times. Extra time was allowed for appointments and home visits to ensure they fully understood the care planned and the events which would take place.
- The birthing pool was available for all women following a risk assessment. Midwives told us they explained to women that if they were assessed as suitable to use it and it was available then they could be cared for in the pool environment.
- Chaperone policy was in place, which ensured all women were appropriately supported and accompanied during intimate examinations.
- Telephone translation services were available when required. Conference calls and face-to-face appointments were organised throughout the antenatal stage.

**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 avoid them re-occurring.
- Information regarding how to complain, including posters, were visible on the unit.

## Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- 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.
- Midwives were clear about their role and levels of accountability.
- Staff told us they felt informed by the managers and received appropriate feedback from meetings and through the intranet.
- The service was centred on the women receiving good level of care and support.

**Leadership of service**

- The care group management team consisted of a care group director, a head of midwifery (HoM) and a care group medical director. The HoM and the care group director came into post in September 2016. There was a lead midwife for community services who was responsible for all MLUs within the trust. There was a manager responsible for the day to day running of the unit, who reported to the lead midwife.. Although these management arrangements were in place to ensure joined-up working, we saw that the unit mostly operated independently of the consultant led unit.
- The unit manager was responsible for the running of the unit including staffing, community midwife support and safety of the women and babies. Staff told us that managers of all levels were visible and very much part of the team.
- Local leadership was described as supportive and approachable. Midwives told us that they were confident that they were listened to but did feel nervous about the future changes to the unit, which were imminent in 2017.
- All staff told us they felt informed by their senior managers who visited the unit and were kept up to date through feedback from meetings and through the intranet.
- We were told that the chief executive visited the unit during the previous year, the new head of midwifery had yet to visit and no board members had visited.

**Vision and strategy for this service**

- The trust values, now included in the appraisal process 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.
- The philosophy of care was to aim to deliver high quality maternity care throughout pregnancy, birth and the post-natal period, ensuring that the birth of a child is a safe, life enhancing experience for the woman, her partner and family.
- Staff were aware of the 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. The midwives understandably felt anxious about the possible changes to their working arrangements.
- The midwives were fully aware and engaged in the trust strategies and the possibility of future reorganisation of the service in 2017.

**Governance, risk management and quality measurement**

- There was a clear governance committee structure with direct reporting from the MLU to the care group leadership team.
- The care group governance committee received regular reports on quality performance, patient experience, serious incidents, complaints, audit and risk. These reports included information from the MLUs. We saw evidence of this in meeting records.
- The MLU did not have its own local risk register. All risks were recorded on the care group risk register, which was reviewed and updated monthly. We saw that the risk register identified and reflected the risks at MLUs such as IT system failures. Risks and responsible owners were appropriately assessed, reviewed and escalated.
- During 2016, the service introduced a maternity dashboard that identified key performance indicators and patient's 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.
- Midwives we spoke with were clear about their role and levels of accountability.
- Quality issues were escalated to head of midwifery through discussion and formally through the electronic reporting system.
- Quality and safety issues were measured on the maternity dashboard. In August 2016 quality and safety report for Oswestry 100% of women who were admitted had been assessed for VTE. Hand hygiene on the unit scored 100% and excellent parentcraft sessions were highlighted.
- Minutes of the monthly ward meetings demonstrated that staff were informed and familiar with the trust's quality and safety issues and those relevant to the unit.

**Culture within the service**

- There was a strong emphasis on promoting safety and well-being of staff and they told us they did feel they were a strong team who supported each other. Occupational health facility was available should enhanced support be required.
- The staff we spoke with told us they felt respected and valued.
- We heard about a service, which was centred on the women receiving a good level of safe care and the necessary support.
- Staff was encouraged to forward 'good news' stories to the trust, celebrating successful outcomes and 'happy' events.

**Public engagement**

- FFT feedback was recorded to listen to the public voice. Feedback of this method was minimal and the staff were looking at ways to encourage a higher percentage of returns. However, the women and their families had sent in positive feedback directly to the unit in the form of cards, letters and pictures.
- Women who lived locally told us that they hoped to deliver at the MLU as it had a good reputation of having caring staff and a good safety record.
- There was a quarterly maternity engagement group, which was a multi-agency meeting with a representative from the CCG, Healthwatch Shropshire, a supervisor of

midwives, the HoM, the patient experience team and service users. We saw meeting minutes for September 2016 where patient experiences were shared and actions developed for areas of improvement.

**Staff engagement**

- Monthly ward meetings with the staffs' own agenda ensured that the staff felt engaged and their views were heard. The staff felt engaged and part of the trust especially with the rotation of midwives into the hospital. Staff felt able to raise issues and concerns; they felt valued by the managers.
- Staff told us their ideas were listened to and they felt very engaged with changes to the service and up to date with the progress of their suggestions. Staff at the unit had participated in the trust wide midwifery survey, which had been used to gain views on how to move forward with the service.
- Noticeboards displayed lots of information about the maternity service and general information about the trusts upcoming events and changes to policies, procedures and protocols.

**Innovation, improvement and sustainability**

- On occasions, local school children had been accepted for work experience following discussion with the head of midwifery.
- One midwife, in her own time, had recently completed a hypnobirthing training course to be able to support women who chose this option during labour.
- The on going review of maternity services was considering the sustainability of all the MLU's across the trusts.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital SHOULD take to improve

- The trust should ensure the unit safety dashboard is available and shared with staff.
- The trust should ensure equipment is stored safely and out of reach of children.