Gloucestershire Hospitals NHS Foundation Trust

Stroud Maternity Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Stroud Maternity Hospital

Requires Improvement 

This report relates to the ratings and information for maternity services based at Stroud Maternity Unit. Stroud Maternity Unit (SMU) is a standalone unit run by a team of midwives who provided care to women and birthing people with low risk pregnancies in Stroud and the surrounding areas. Any necessary transfers were made to the consultant led unit at Gloucesteshire Royal Hospital, which was 11.5 miles away.

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

Stroud Maternity Unit (SMU) includes a birth centre, antenatal clinic, and conservatory area where additional support services were provided.

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

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

This location was last inspected under the maternity and gynaecology framework in 2015. Following a consultation process CQC split the assessment of maternity and gynaecology in 2018. As such the historical maternity and gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location. This does not affect the overall Trust level rating.

We rated Stroud Maternity Unit as Requires Improvement:

How we carried out the inspection

We provided the service with 3 working days' notice of our inspection.

We visited the antenatal clinic, the birth centre, and the closed postnatal bay.

We spoke with the consultant midwife, 1 matron, 4 midwives, 1 maternity support worker, and 1 student midwife. We were unable to speak with any women and birthing people. We received 2 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 5 patient care records and 5 observation and escalation charts.

Our findings

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

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

Maternity

Requires Improvement

We rated it as requires improvement because:

- Compliance for safeguarding training was low, staff did not always ensure equipment was safe and ready for use and medicine management was poor.
- Staff did not always complete risk assessments or follow policy to ensure women and birthing people were suitable for care and birth, and documentation was not always contemporaneous.
- There was ineffective governance process and oversight, and leaders did not always manage risk and manage safety incidents well. Leaders did not always use reliable information to evaluate and run the service and there was limited engagement with the team and community to review and develop the model of care and services provided.

However:

- Staff had training in key skills and controlled infection risk well.
- The team at Stroud Maternity Unit worked well together for the benefit of women and birthing people and were passionate about the philosophy of the unit.

Is the service safe?

Requires Improvement

Mandatory training

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

Midwifery staff and maternity care assistants received and kept up-to-date with their mandatory training. Ninety-five per cent of staff had completed all mandatory training courses against a trust target of 90%. All maternity staff were required to complete trust level mandatory training as well as maternity specific mandatory training.

The mandatory training was comprehensive and met the needs of women, birthing people, and staff. Training included intermittent auscultation and cardiotocograph (CTG) competency skills. A fetal monitoring competency assessment was required to be completed by all midwifery staff, with a minimum pass rate of 80%. Any staff who failed were required to repeat the training day and assessment and offered one-to-one support. Staff were not allowed to care for women and birthing people in labour unless they passed the competency test.

The service made sure staff received multi-professional simulated obstetric emergency training (PROMPT). Theory based learning was held at Gloucestershire Royal Hospital and following staff feedback practical sessions were held at Stroud Maternity Unit (SMU).

Training compliance was amalgamated with the 2 other locations but consistently over 90% for all staff groups. Midwifery compliance for PROMPT was 93% and maternity support workers was 90%. There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies.

Maternity

Managers monitored compliance for mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training and were given protected time to compete it.

Safeguarding

Staff understood how to protect women and birthing people from abuse. Staff training compliance on how to recognise and report abuse was poor.

Staff did not always receive training specific for their role on how to recognise and report abuse. Training records showed that only 63% of staff at Stroud Maternity Unit (SMU), had completed Level 3 safeguarding children training. This was not in-line with the trust's target of 90% and the intercollegiate guidelines. Safeguarding Level 3 training for adults was also part of mandatory training for midwives but the trust did not provide any evidence of compliance.

The trust was also not compliant with NHS England /Improvement Southwest Safeguarding Training Framework 2022–2025 which stated that all clinical staff working with children, and/or adults with care and support needs must have Level 3 safeguarding training in children and adults.

Staff that we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. They told us there was a vulnerable team who they could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

We saw that SMU was secure, and doors were monitored. The service had an up-to-date policy for baby abduction, but staff were unsure when a baby abduction drill was last completed. We did not see any evidence that it was part of mandatory skills and drills or that staff had recently practised it. Staff were not adequately trained to respond to the risk of baby abduction as they had not completed baby abduction drills.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect women, birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

All areas of Stroud Maternity Unit (SMU) were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Flooring in clinical areas and associated corridors allowed for effective cleaning. Curtains were visibly clean and disposable. The change date was recorded and there was a process to ensure a regular cleaning regime.

Staff cleaned equipment after contact with women and birthing people. They cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE) which was stored in wall mounted displays. We asked leaders to share the results for infection prevention and control (IPC) and hand hygiene audits for SMU for the past 3 months. The trust provided hand hygiene audit result for October and December 2023 (up until our visit) which showed 100% compliance. However, there were no results for November 2023 and leaders did not share any of the IPC results that we requested.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

There was clear information displayed regarding infection prevention and control measures. For example, safe management of equipment, linen, waste management and PPE, although we saw that posters and information on display was not always laminated which posed an infection risk because information could not be effectively cleaned.

Environment and equipment

The service had enough suitable equipment, but they did not always check it or complete electrical safety checks to ensure equipment was safe and ready for use. Staff disposed of clinical waste safely.

The design of the environment did not follow national guidance. We asked the trust to provide evidence for their environmental ligature and ligature point risk assessment, but they did not provide this nor did they provide information that this was done on a case by case basis. In addition, we saw that cord pulls in bath and shower rooms were not ligature free.

There was a reception area on entry and a private office for staff to complete administrative work and receive handovers in a confidential environment. There were 3 labour/birth rooms on the birth unit, although 1 room was generally used for labour assessments and perineal suturing. The labour rooms were ensuite, spacious, with dimmable lighting, electric candles, and music to promote a calm and tranquil environment.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was observation monitoring equipment and there were pool evacuation nets in the birth centre. However, we did not see evidence of drills to practice an emergency evacuation from the pool.

There were 2 resuscitaires and emergency equipment situated within reach of each room. We saw evidence that daily safety checks were completed for the month of November and up until our visit. All items were present and in-date although the clinical flow-charts/action cards were out-of-date. We asked the trust to provide evidence of equipment checks for the previous 3 months but they were only able to provide data for November 2023.

Action-cards/algorithms (which included what medicines to use in an emergency) on the obstetric emergency trolley, had passed the review date of March 2023.

Call bells and emergency bells were accessible to women and birthing people if they needed support. The birth partners of women and birthing people were supported to attend the birth and provide support and there were suitable facilities to meet the needs of women and birthing people's families.

Staff disposed of clinical waste safely. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal. Sharps bins were labelled correctly and not over-filled.

Assessing and responding to risk

Staff did not always complete and update risk assessments to remove, minimise or manage risks.

Risk assessments were carried out by community midwives throughout pregnancy. Staff told us that pregnant people requesting to birth at Stroud Maternity Unit (SMU), had an assessment at 36 weeks and onset of labour. We asked the trust to provide audit results for the previous 6 months and although 100% of assessments were completed at the onset

of labour, average compliance for assessments at 36 weeks was only 35%. This meant leaders could not assured women and birthing people were always suitable to birth at SMU. We saw there were some recommendations to improve the results but there was no date of when they were implemented, and the results had deteriorated rather than improve. For example, only 54% were completed in July 2023 and only 18% in December 2023.

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) to identify women and birthing people at risk of deterioration. We reviewed 5 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. The monthly MEOWS audit for SMU showed only 38% of scores which triggered the need for repeat observations in 1 hour had them repeated, and only 63% were appropriately escalated. This meant leaders could not be assured staff were identifying and escalating deteriorations in condition in a timely manner.

There was no dedicated phone to call for an ambulance in an emergency and there was no dedicated phone on the delivery suite at the consultant led unit to receive calls regarding emergency transfers. Staff told us they would call the Flow Coordinator if the phone-line was busy and that there had never been any delays because of this. Staff were able to describe what action they would take while awaiting an ambulance response.

We noted that staff highlighted concerns about the urgency of ambulance requests for certain transfers during the maternity safety champion walkabout in October 2023. They were concerned that there could sometimes be a disagreement with their local ambulance service regarding the urgency of an ambulance and although we saw this feedback recorded, we did not hear of any actions that had come to fruition.

There was a weekly multidisciplinary (MDT) meeting to discuss women and birthing people who wanted care and birth outside of guidance. The meeting included a consultant obstetrician, consultant midwife and matron. Midwives made electronic referrals and discussed the care/birth that women and birthing people wanted. Following the factual accuracy process, leaders shared details of this pathway as we did not hear how women and birthing people were involved in the discussions about their requests and plans.

The shared pathway outlined that the MDT meeting should be used to discuss the most appropriate health care professional/s (hcp) to support the request and plan care. A follow-up meeting known as a Birth Options Care Planning Appointment was then arranged for the woman/birthing person, their lead midwife and/or obstetrician and most appropriate hcp(s) to support the request and plan of care. Leaders told us the pathway had been recognised as an excellent initiative by the Royal College of Midwives and Royal College of Obstetricians.

Staff from SMU joined the bi-daily safety huddles virtually at the consultant led unit to ensure all staff were up-to-date with key information. The huddle shared information across both locations about activity, acuity, risks, safeguarding and safety information.

We were unable to observe a clinical handover as no one was in labour when we visited. We requested audit results for compliance to a nationally recognised tool to support effective handovers which described the situation, background, assessment, recommendation (SBAR) situation, but did not receive any results. We could not be certain leaders were assured of the quality and consistency of clinical handovers.

The service had access to specialist mental health support from a multidisciplinary perinatal mental health team who prioritised women and birthing people with serious mental health needs. The Birth Anxiety and Trauma Service was part of the perinatal mental health team and provided psychological support following birth trauma, fear of birth or pregnancy and baby loss.

Maternity

Midwifery Staffing

The service had issues with recruitment and retention of staff. Staffing levels did not always match the planned numbers which put pressure on the team to work additional shifts.

The team was 3 whole time equivalent midwives under establishment; 2 posts had been filled with start dates of January and February 2024 and there was a live advert for the remaining post. Staff told us the team at Stroud Maternity Unit (SMU), or community midwives covered any unfilled shifts to ensure staff were always familiar with the service.

Leaders told us they monitored staff hours to ensure they did not work over the working time regulations (1998), although this still placed additional pressure on staff to ensure 24- hour cover.

Staff at SMU were not part of the trust-wide maternity escalation process, and the first on-call community midwife was protected from escalation in order to support any births at SMU. The unit had not needed to close during the past 12 months.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A maternity 'red flag' event is a warning sign that something may be wrong with midwifery staffing. However, we could not determine if there were any red flags related to SMU as red flags were reported trust wide.

A ward clerk supported the team with administrative duties from 8am-1pm, Monday-Friday. The team leader was on duty during daytime hours to maintain oversight of staffing, acuity, and capacity. However, they were often required to work clinically to fill vacant shifts during day or night-time hours which impacted on managerial duties. For example, only 69% of staff had a recent appraisal.

Records

Staff kept records of women and birthing people's care and treatment. Records were clear and stored securely although we saw evidence that documentation was not always contemporaneous.

Information governance and data security was included in annual mandatory training although the trust did not confirm compliance to this for staff at Stroud Maternity Unit.

The trust implemented electronic patient records in June 2023. There were 2 digital midwives to support midwives in the transition until the end of March 2024. Some staff told us this was causing anxiety as they were not aware of what support would be provided following this. However, during the factual accuracy process leaders confirmed there was 1 permanent Band 7 digital midwife in post and a live advertisement for an additional 12-month fixed term Band 6 post.

We reviewed 5 electronic records which were clear but not fully completed as 3 records did not include a surgical checklist when perineal suturing was required. All other checklists and risk assessments were completed in full.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

However, we reviewed an incident and noted that documentation was not contemporaneous and there were discrepancies in timelines which could have been because the record was completed 3 days following the incident when it would be difficult to accurately recall key information.

Maternity

Medicines

The service did not always store and manage medicines safely.

Staff did not store and manage medicines safely. We saw medication that was out-of-date and still in use. This included Adrenaline that could be required in an emergency and had expired in November 2023, and 25 bottles of ultrasound gel that had expired in October 2023. There was an open bottle of Oromorph which did not include the date it was opened. This medication is supposed to be discarded after it has been opened for 90 days. We asked why Oromorph was on the unit and were told it was for when they provided postnatal care, even though the postnatal beds had been closed in October 2022. This meant leaders could not be assured daily checks in SMU were effective, and that staff acted when there was out of date medicines.

We highlighted these issues immediately to senior staff who reassured us that they had contacted pharmacy and arranged for the medication to be discarded.

We found the medicines fridge had not been checked daily in line with best practice guidance and trust policy. We visited on 12 December and the fridge had not been checked on 2 of these 12 days. In addition, there were no records available for previous months. Thermometers to monitor the ambient temperature in the clinical room where medicines were stored were installed on the day of our inspection. This meant leaders could not be assured medicines were stored at the correct temperature prior to this.

We were told that the daily checks were generally completed by night staff but if someone was in labour the task was handed over to day staff. The matron-of-the day contacted the unit every morning and asked if they were ‘safe to respond.’ This was described as an assurance contact to ensure all safety checks had been completed. The team were also asked if they were ‘safe to respond’ when they joined the whole team safety huddle evening morning and evening. However, our observations found these processes were not effective.

Following our visit, we asked leaders to provide evidence of medicine audits for the last 3 months but were told safe storage of medicines was not audited. Leaders advised they were commencing medicine audits in January 2024 following the issues we highlighted.

Action-cards/algorithms which included what medicines to use in an emergency on the obstetric emergency trolley had passed the review date of March 2023.

Medicine management training was part of the trusts mandatory training programme, but compliance was only 70% against a trust target of 90%.

Midwives may administer or supply medicines under midwife exemptions, without the need for a prescription. Staff were aware of their ability to prescribe drugs on a midwives’ exemption. A list of drugs approved for administration by registered midwives under midwives' exemptions was available on the trust internet.

Staff checked controlled drug stocks daily. Records for checking controlled drugs demonstrated 2 staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

Staff told us prescription charts were paper based, however we were unable to review any prescription charts during our visit

Maternity

Incidents

Staff recognised and reported incidents. Managers investigated incidents and supported staff but did not always identify learning.

Staff knew what incidents to report and how to report them. Staff could describe what incidents were reportable and how to use the electronic reporting system. The guideline to support staff report incidents titled 'Reporting and managing safety incidents using the incident management' was over 1 year past the review date.

Staff reported all transfers to the consultant led unit. Leaders told us all transfers were reviewed by the team leader or matron for Stroud Maternity Unit (SMU), to determine if they had been timely, appropriate and identify any care issues. Staff told us they always provided feedback to the primary midwife and more generally at team meetings to share learning.

Leaders recently introduced a new process for the review and management of incidents. Incidents were reviewed daily at the Flow and Quality Meeting attended by the Band 7 clinical and risk midwives and senior midwifery team. This meeting was held on Teams and leaders told us a Band 7 midwife at SMU often attended.

Leaders told us that any incidents that were of moderate or severe harm, required further information or met national priorities were allocated to a Band 7 midwife or matron to investigate, discuss the appropriate response and identify any lessons learned. In addition, any incident that met the threshold for a Serious Incident was reviewed at 1 of the bi-weekly Patient Safety Review Meetings which was attended by the multi-disciplinary team.

However, we saw evidence of inconsistencies in the summary and timeline of about 1 hour in 1 incident. This could mean there was a significant delay in a transfer to the consultant led unit. This evidence also demonstrated staff in SMU did not follow trust policy in the mode of transport to the consultant led unit. The investigation did not identify any omissions or gaps in the care provided by staff in SMU. However, following our review we found there were clear areas for learning and improvements which should have been identified.

Staff received feedback from investigation of incidents although they focused on incidents related to SMU rather than extending learning from incidents trust wide.

Leaders told us staff were debriefed and supported following incidents and difficult shifts and given a variety of support options. It was clear from managers that supporting staff was a high priority.

Staff meetings were held weekly to discuss feedback and look at improvements to the service. Leaders told us meetings were minuted and available to the teams, although meetings were regularly cancelled due to staffing issues.

Is the service well-led?

Requires Improvement

Leadership

Local leaders were visible and approachable in the service for women, birthing people, and staff.

Maternity

Stroud Maternity Unit (SMU) was managed as part of the Women and Children's Division of Gloucestershire Hospitals NHS Foundation Trust. This division was managed by a chief of service, a divisional operational director, and a director of midwifery (DoM). This included specialty directors for obstetrics and paediatrics (which included neonatal). The DoM was supported by a head of midwifery, consultant midwife and matrons.

On a local level, SMU was managed by a team leader who was supported by a community matron who took up post in June 2023. The community matron told us they worked clinically 20% of the time and that this helped them to understand issues and where improvements were needed.

There was a consultant midwife who had taken up post in May 2023 who told us they provided expert advice, clinical leadership, and senior support to the unit.

Many of the senior midwifery posts were fairly new appointments and not fully embedded including the HoM, consultant midwife and matrons. Leaders told us the senior midwifery team had completed a leadership course together which helped them to develop as a team.

Maternity services had 5 safety champions. This included a non-executive director (NED). The board safety champions told us they engaged with staff and service users on walkabouts, to obtain views on safety. There was a formal plan to outline the frequency of walkabouts for each location and we noted 4 had occurred on SMU during the 8 months prior to our visit.

The executive team and senior leadership team also visited although there was no formal plan to outline the agreed frequency.

Leaders had a clear understanding of the challenges to the quality and sustainability of SMU. Stroud maternity staff actively promoted the unit and services available, but the number of births had declined over the past couple of years and the postnatal beds had been temporarily closed since October 2022.

Vision and Strategy

There was a trust wide maternity vision but no location specific vision for what it wanted to achieve. There was a draft trust wide maternity strategy.

The vision for maternity services was to provide excellence in care as measured by their outcomes, user experience and staff values. The key drivers were workforce and wellbeing, engagement, education, and training, listening, and learning. Leaders shared their strategic plan for 2022-2023 which focused on the delivery of the recommendations following the Ockenden review and reports (2020, 2022), and included the 15 Immediate and Essential Actions. The plan was to also continue their improvement work which had already been commissioned.

However, this was at a development stage, and we could not see how staff had been involved or consulted with the plan.

Culture

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

Maternity

Staff felt respected, supported, and valued**.** All staff we met during our visit were welcoming, friendly and helpful. They were passionate about working at Stroud Maternity Unit (SMU), supporting choice and normality. They described the team as 'like family,' felt able to speak to leaders about difficult issues and described the management style as supportive and inclusive. There was an emphasis on close working which included community midwives providing on-call cover for intrapartum care.

There were historic tensions between staff at SMU and the consultant led unit. Leaders were aware of this and felt this was largely due to not fully understanding each other's work and workload, although there did not appear to be any plans to improve this. However, the team at SMU described an appreciation and understanding of differences between their model of care and that of the consultant led unit, who they supported with some planned work. For example, breastfeeding support, checks prior to elective caesarean sections and blood tests.

Staff were focused on the needs of women and birthing people receiving care and promoted a culture that placed peoples' care at the heart of the service. Dignity and respect were intrinsic elements of the culture. There were privacy curtains around clinical areas, and visible alerts to remind staff to 'STOP/THINK/ask before entering' and staff made it clear that women and birthing people could request a chaperone for examinations and appointments.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service had a public health midwife and public health team and the practice development team had developed training resources that focused on reducing risk and inequalities trust wide. For example, they had developed a training video that centred on a same sex couple who wanted to give birth at SMU, outside of guidance.

The service promoted equality and diversity in daily work and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement, and staff told us they worked in an inclusive environment.

However, there was inequality in the choices available to women and birthing people booked with SMU compared to the consultant led unit. They could access a range of free-of-charge services, delivered in collaboration with maternity staff. We were told the additional services were well received by mothers and midwives but there did not appear to be any recognition of the inequity between the choices across the trust, or any attempt to be more inclusive and extend some of the services more widely.

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. The trust had a Freedom to Speak up Guardian and a National Whistleblowing Helpline which was an independent and confidential advice.

We saw and heard how staff wellbeing was supported at SMU. There were resources such as Applications (Apps), details of how to self-refer for counselling and useful information to promote/maintain a healthy lifestyle.

There had not been any recent complaints related to SMU, but the service clearly displayed information about how to raise a concern in areas used by women, birthing people, families and visitors. Staff understood the policy on complaints, how to handle them and the importance of learning from any complaints at SMU or the consultant led unit.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations.

Maternity

Maternity services had a perinatal and governance lead supported by a perinatal quality lead, patient safety team, practice development team, education and recruitment and retention team. The matron for Stroud Maternity Unit (SMU), attended monthly governance meetings, which included an update on recruitment and training compliance, review of risks, incidents, guideline updates and review of the maternity dashboard. However, a separate governance report was not produced for SMU, and we could not see that it was an agenda item to ensure issues and improvements were always considered. The unit did not specifically feature in quality reports, and it was difficult to see how the board could maintain oversight.

The trust had not met 3 out of 10 safety actions for year 4 of the Maternity Incentive Scheme (MIS). The MIS rewards trusts meeting the 10 safety actions designed to support the delivery of best practice in maternity and neonatal services through an incentive element to trust contributions to the Clinical Negligence Scheme for Trusts. The un-met safety actions included: avoiding unnecessary term admissions of babies, compliance with all 5 elements of the Saving Babies' Lives care bundle (v2) and demonstrating that there were robust processes in place to provide assurance to the board on maternity and neonatal safety and quality issues.

Leaders did not have oversight of medicine management and it was difficult to understand how these issues had not been identified internally, as part of audit and governance process.

Electrical safety testing was not always completed for equipment. We noted some clinical equipment checks were out-of-date and the trust did not provide evidence of electrical safety checks which we requested. Leaders had not assured themselves that equipment was safe and ready for use.

Leaders did not have an effective process to monitor policies and review dates and the ownership, oversight and management of guidelines and procedures at SMU was unclear. We noted that some policies and algorithms were out-of-date which meant they might not reflect evidence-based practice and national guidance. Leaders told us they monitored policy review dates on a tracker and the updated guidelines were written and waiting to be uploaded onto the intranet, but a delay had occurred because maternity services wanted algorithms included that the trust did not want to sign off. This appeared to have caused an unnecessary delay and there were no mitigations until there was agreement.

Maternity services had an audit plan for 2023-2024 but we noted that 7 were overdue at the time of our visit and we could not see any audit or evaluation of services provided at SMU. Equally, audit of transfers from SMU to the consultant led unit was not reflected in the plan. We asked the trust to provide details of all transfers for the previous 6 months and whilst they provided some information it did not include outcomes such as length of labour, analgesia, perineal tears, blood loss, condition of baby at birth and birth weight. We also noted that key information was often missing. For example, the time of decision to transfer, the time the ambulance arrived at SMU and time of arrival at the consultant led unit. This was a particular concern given that delays with ambulance times was a known risk reflected on the maternity risk register and this was not effectively monitored and scrutinised to mitigate any risk.

In addition, staff told us they discussed potential transfer times and reasons for transfers at the antenatal appointment at 36 weeks. However, the audit did not evidence this conversation had taken place, and this information was also not available on the trust website. This meant leaders could not be assured women and birthing people had received sufficient information to make an informed decision about birthing at SMU.

The SMU offered many additional services to support pregnant people, new parents, and babies. For example, social events to introduce prospective parents to the service, baby singing and yoga. These services relied on funding raised by a local charity, however, there was no formal evaluation of their impact.

The practice development team produced a training plan which was agreed and ratified by the clinical governance committee and included risks and themes from the previous year to ensure training addressed any issues or concerns. The team produced an annual statistics report and action plan to address training issues and shortfalls and monthly compliance training figures for the senior midwifery team and trust board oversight

Learning and good news stories were shared from reviews through governance boards and closed Facebook groups for staff and emails, although the boards were very cluttered. This meant information was not organised and clearly visible.

Management of risk, issues, and performance

Leaders and teams did not always identify actions to reduce risk.

Stroud Maternity Unit (SMU) did not have a local risk register. The risks relating to closure of the unit due to staffing pressures or maintenance issues was not identified and therefore not mitigated as a risk.

We noted 6 actions on the risk register which were overdue, and there were sometimes delays in the review of risk(s).

Pathways around the local ambulance service for transfers to the consultant led unit needed strengthening. We noted staff raised concerns with the maternity safety champions in October 2023 about potential disagreement regarding the categorisation of response times, and although this was on the risk register, we did not hear or see of any meaningful mitigations.

Leaders told us staffing was their biggest risk but felt assured that the director of midwifery and their team had introduced systems to assure themselves that staffing was reviewed regularly. The postnatal beds were temporarily closed due to staffing vacancies and leaders told us the plan was to reduce the number of vacancies and then to reopen the beds. The decision to keep the postnatal beds closed was regularly reviewed by leaders and executive teams.

Information Management

The service did not always collect reliable data and analyse it. Data or notifications were consistently submitted to external organisations as required.

Stroud Maternity Unit (SMU) did not always collect reliable data and analyse it. Maternity services had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. The number of births for SMU were separated. However, all other data was reported trust wide. Equally, data on birth outcomes, breastfeeding support and support groups was not collected or scrutinised. Managers did not have complete oversight, were not always able to identify issues and monitor improvements specific to the unit.

Midwives collected data to identify higher risk women and birthing people at all booking appointments such as high body mass index and co-morbidities. This was used to plan individual care needs and determine suitability to birth at SMU. Staff collected data regarding ethnicity and if women and birthing people were a recent migrant, refugee, or asylum seeker, although this data was also amalgamated across all 4 locations.

Data or notifications were consistently submitted to external organisations as required. This included the National Neonatal Audit Programme, MBRRACE-UK and Maternity and Newborn Safety Investigations Special Health Authority. They had also completed the national perinatal review tool since the launch. This helped to ensure consistency of reporting nationally.

Engagement

Leaders did not actively and openly engage with women, birthing people, staff, the public and local organisations to plan and manage Stroud Maternity Unit. The collaboration with partner organisations to help improve the unit was minimal.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. However, the membership was not representative of the demographics, and the MNVP needed more support so that less vocal people were also represented.

The MNVP held 4 partnership meetings in 2023 and discussed themes from user feedback and ideas for improvements. Actions were agreed at the maternity experience subgroup. The meetings also included updates. For example, in September 2023 the director of midwifery gave an update on the maternity strategy. The trust set up a bi-monthly maternity patient experience meeting. These meetings commenced in October 2023 and leaders told us the MNVP were invited to attend and actions and outputs were closely monitored by the Board Safety Champion and the executive led Maternity Delivery Group meeting.

The MNVP had good engagement and a positive relationship with SMU staff, and they were planning the agenda for their joint meeting in March 2024. However, the team at SMU lacked the autonomy to make decisions about improvements or quality projects and meetings appeared to be more about information sharing.

In addition, although leaders told us they coproduced resources with the MNVP examples were limited.

We saw no evidence that leaders had engaged with the community to discuss the model of care or temporary closure of postnatal beds, although leaders had communicated that Stroud Maternity Unit (SMU) remained available as an option for birth, postnatal care for the first 6-12 hours, and breastfeeding support.

The website for SMU included very little information and there was no information to confirm inclusion criteria, process for booking, transfers, journey times, statistics, or feedback from service-users. Equally, some of the information was out-of-date. This included the provision of 6 postnatal beds. The website contained insufficient information to promote the service or support informed decisions.

The trust shared details of the NHS staff survey results for the Women and Childrens' Division in 2022. There was nothing separate for staff at SMU but leaders had created a joint organisational safety culture plan with the Local Maternity and Neonatal System which supported actions related to the results.

We noted that staff raised concern about lack of engagement between leaders and the team during the maternity safety champion walk-about in October 2023. The team were concerned that decisions which involved them were made without any consultation and although we saw this recorded in the minutes of the walk-about, we did not see evidence of any discussion around solutions.

Maternity

Team meetings at SMU were scheduled monthly but staff told us they generally happened about every 2 or 3 months because of capacity. However, SMU staff were invited to monthly meetings led by the director of midwifery/matrons. These meetings were held on Teams, recorded, and shared by email, for all staff to access.

We only received 2 responses to our give feedback on care posters which were in place during the inspection which were both positive.

Learning, continuous improvement and innovation

Stroud Maternity Unit was a valued community resource and various events were maintained to support new parents. These included social events for parents and new babies, yoga and singing-sessions, a pelvic health group, a coffee afternoon for women and birthing people to introduce them to SMU as an option for birth, infant feeding support and more. This included integration of Voluntary Sector organisations.

Outstanding practice

We did not find any outstanding practice.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure staff are up-to-date with mandatory safeguarding training. Regulation 12(1)(2)(c).
- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1)(2)(a)(d).
- The service must improve the governance of medicine management. Regulation 12(1)(2)(g).
- The service must ensure that staff complete accurate risk assessments to determine if women are suitable for assessments and to birth at Stroud Maternity Unit. Regulation 12(1)(a)(b)
- The service must ensure there is a process to ensure oversight and management of policies, guidance, and procedures to ensure they are reviewed in a timely manner, are clear and reflect national guidance Regulation 17(1)(2)(a).
- The service must ensure they have regular audit to demonstrate compliance with standards and procedures, to identify gaps, implement and monitor improvement Regulation 17(1)(2)(a)(b).

Action the trust SHOULD take to improve:

- The service should consider the need for a separate risk register for Stroud Maternity Unit.
- The service should consider separating data collection between locations and to use this to drive improvements.

Maternity

- The service should consider how they can improve the model of care to ensure it is fit for purpose.
- The service should consider how they can evaluate the additional services and use this to make improvements.

Our inspection Team

The team that inspected the service comprised a CQC lead inspector, and 1 specialist midwifery advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care

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