Royal United Hospitals Bath NHS Foundation Trust

RD1

Other specialist services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RD102	Chippenham Community Hospital	Community Maternity Services	SN15 2AJ
RD108	Trowbridge Community Hospital (Maternity)	Community Maternity Services	BA14 8PH
RD121	Frome Birth Centre (Frome Community Hospital)	Community Maternity Services	BA11 2FH

This report describes our judgement of the quality of care provided within this core service by Royal United Hospitals Bath NHS Foundation Trust . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Royal United Hospitals Bath NHS Foundation Trust and these are brought together to inform our overall judgement of Royal United Hospitals Bath NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall we rated the community maternity services as good. We rated the service as good for the effective, caring, responsive and well led domains because:

- There were effective incident reporting systems in place. Staff confirmed they received feedback and learning points.
- Staff understood the safeguarding processes in place. They had access to support and were knowledgeable about the subject.
- There were robust risk management and governance systems and processes in place. Staff felt engaged in the processes and received good support from the risk management team. Regular meetings were held at birthing units and in community teams with information flowing to directorate and trust level and back again.
- There was an ongoing audit programme. There were a number of national and local audits ongoing during the inspection. There were good clinical outcomes for women using the community maternity services.
- Women and their families received personalised care. There was additional support for women who had a learning disability or whose first language was not English.
- Women received care and support from experienced midwives who were kind and compassionate and maintained women's privacy and dignity.
- Systems were in place to support access and flow through the birth centres.
- There were systems to share information and learning.
- There was strong interim leadership in place. A positive culture was evident at all of the services we visited.

However, we have judged the safety domain as requires improvement because:

- Improvements were required in record management around secure storage of community midwives completed diaries. An action plan and Standard Operating Procedure were urgently developed by the service following the inspection which identified a robust mechanism for the storage of community midwife diaries.
- Improvements were required in the management of medicines in terms of consistent management and checking for out of date stock across all of the community services.

Summary of findings

Background to the service

The Royal United Hospitals trust provided a range of maternity services in the Royal United Hospital (RUH) and in community settings in Bath, Wiltshire and Somerset. This section of the report covers midwifery led birthing centres and community midwifery provision within the geographical area covered by the trust. For details of consultant led care in the Royal United Hospital (RUH) please read the maternity and gynaecology section of the Royal United Hospital location report.

Birthing centres (also called birthing units or midwifery led units) are smaller places for women to give birth, where the emphasis is on natural birth, without medical intervention. Care in a birthing centre or at home is usually only offered to women who are at low risk of complications during labour, as there are no medical facilities within the birth centre. The midwives in birth centres are experts in complication-free pregnancy and birth. They take care of women during labour, but if complications do happen, and a doctor is needed, they make sure that women are transferred to a labour ward in a consultant (doctor) led unit.

Midwifery led intrapartum care, for women assessed as low risk was provided at five units located in Trowbridge, Chippenham, Paulton, Frome and Shepton Mallet. Women assessed as low risk also had the option for a home birth. Paulton Birthing Centre was temporarily closed at the time of the inspection. Paulton Birthing Centre had two birth rooms, a post-natal stay area and additional multi-function rooms which were used for clinics. We did not inspect services provided at Shepton Mallett during this inspection.

Chippenham Birthing Centre had three delivery rooms, four post-natal beds and two assessment beds that could be used for inpatients if necessary. The centre also ran ante-natal clinics, post-natal clinics and parent craft sessions.

Frome Birthing Centre had three delivery rooms and one multi-function room. The unit did not have any inpatient beds but held ante-natal and post-natal clinics, and assessed women who thought they may be in labour.

Trowbridge Birthing Centre had two delivery rooms and one multi-function room where women in early labour or who needed assessment could stay.

Bath did not have a birthing centre but there was a team of community midwives and maternity support workers who provided ante and post-natal care in the local community at GP surgeries and local health centres, and at RUH adjacent to the Day Assessment Unit. Women had the option of a home birth, or at any of the midwifery led birth centres. If women decided to birth in Royal United Hospital their care was midwifery led. A consultant was assigned only if women were assessed as high risk.

Each birth centre provided on call cover, however overnight the coordination of this was allocated to either Chippenham or Trowbridge birth centre with the added support of a band 7 Sister being available in the obstetric unit at RUH for further advice if required.

There were approximately 240 deliveries a year at Frome Birthing Centre.

There were approximately 200 deliveries a year at Chippenham Birthing Centre.

There were approximately 290 deliveries a year at Trowbridge Birthing Centre.

There were approximately 150 deliveries a year at Paulton Birthing Centre

There was a 4% home birth rate achieved by the community midwifery teams.

During our inspection we spoke with three patients and 27 staff across the birthing centres and community teams. These included women and children's directorate leads, interim matrons, midwives, maternity support workers, ward clerks/administrative staff and cleaning staff.

We reviewed four sets of records. We reviewed data supplied by the trust before, during and after the inspection.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Matthew Kershaw, Chief Executive, East Kent Hospital University Foundation Trust

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

The team included a CQC inspector and a specialist advisor, who was a senior midwife.

Why we carried out this inspection

We inspected the Royal United Hospitals Bath NHS Foundation Trust as part of our programme of comprehensive inspections of all NHS acute trusts.

How we carried out this inspection

We carried out the announced part of our inspection between 15 and 18 March 2016.

During the inspection we visited three midwifery led birthing centres and community midwifery provision within the geographical area covered by the trust. We spoke with clinical and non-clinical staff, patients and relatives. We held focus groups to meet with groups of staff.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical Commissioning Groups and Monitor (now NHS Improvement).

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

What people who use the provider say

- Three women who had used the maternity services we spoke with were very positive about their experiences and information provided to them throughout their pregnancy, labour and post-natally. They felt fully informed and empowered to make choices about where and how to have their baby.
- Women and their relatives we spoke with said they were provided with information and had their treatment options discussed with them. They said they felt able to ask questions and got clear answers.
- The CQC survey of women's experiences of maternity services 2015 found that the trust scored about the same as other trusts when involving a partner or someone close to the woman during labour and birth.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the hospital MUST take to improve

- Must take action to ensure that community midwives diaries are stored securely for at least 25 years.

Action the hospital SHOULD take to improve

- Should ensure all medicines are in date and a system for checking stock medication is introduced.
- Should ensure there was evidence that equipment had been cleaned after use.

Summary of findings

- Should ensure there was evidence equipment that was the responsibility of the trust that owned the building (which may not be Royal United Hospitals Trust) had been cleaned, reviewed or renewed in line with that trusts policies.
- Should ensure the safety of community midwives using rooms at Royal United Hospital Trust maternity unit, out of hours when there were no other hospital staff nearby and accessing home birth equipment at night.
- Should ensure all of the birthing centres had carried out a practice emergency evacuation from their birthing pool.
- Should ensure there was evidence to show which women were risk assessed as suitable for home births or delivery at a birth centre.
- Should ensure there was evidence to show what increased risks would require a woman to be transferred for consultant care and/or hospital delivery.
- Should ensure maternity birthing equipment to assist with pain and discomfort during labour and birth was available.

Care Quality Commission

Royal United Hospitals Bath NHS Foundation Trust

Other specialist services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We judged safety as requires improvement because:

- Improvements were required in the management of medicines in terms of consistent management and checking for out of date stock across all of the community services.
- Improvements were required to evidence equipment had been cleaned after use.
- Improvements were required to evidence that oxygen and suction tubing had been renewed and dates recorded in line with that trusts policies.
- Not all of the birthing centres had carried out a practice emergency evacuation form their birthing pool.
- Improvements were required to evidence which women were risk assessed as suitable for home births or delivery at a birth centre.
- Improvements were required to evidence what increased risks would require a woman to be transferred for consultant care and/or hospital delivery.
- In order to meet working time directives legislation, the on-call system overnight meant that midwives often worked into their days off, meaning they did not get the benefit of full days off. However, the trust told us the on call system had been piloted at one of the birthing centres without any concerns being raised. They added that community midwives contracts did have an expectation that on call duties would be carried out.

However, good practice was also seen:

- There were effective incident reporting systems in place. Staff confirmed they received feedback and learning points.
- Staff understood the safeguarding processes in place. They had access to support and were knowledgeable about the subject.
- There was evidence Duty of Candour regulations were understood and followed.
- There was a range of medical equipment available to staff including blood pressure and pulse monitors and handheld sonicaid machines to monitor the fetal heartbeat. Staff said if any piece of equipment became unserviceable it was quickly repaired or replaced.
- Comprehensive individual risk assessments were carried out throughout a woman's pregnancy.

Incidents

- Staff were clear about how to report incidents. Most staff we spoke with said they received feedback when they reported incidents via their electronic reporting system.

Requires improvement

Are services safe?

- The maternity and gynaecology services maintained a joint incident log which included incidents reported at the birthing centres or about community services.
- We looked at meeting minutes that detailed reported incidents, specific learning requirements or changes to policies. Daily safety briefs were held at each shift handover which included incidents and required learning.
- Between February 2015 and January 2016 there were 14 serious incidents reported across the maternity and gynaecology services. None of these originated from community based services.
- The Supervisor of Midwives (SOM) was made aware of incidents involving midwives and provided support to midwives as required.
- Community staff were invited to attend the maternity services morbidity and mortality meetings which covered the whole of the trust's maternity services. We saw attendance lists for March, July and October 2015 that showed the names of community based staff who had attended. Staff who did not attend felt they would be kept up to date about any mortality or morbidity concerns via the weekly trust newsletter or the monthly newsletter (Incident Informer) by the patient safety team.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred. The trust should provide reasonable support to the relevant person in relation to the incident and offer an apology.
- There was no formal training programme for Duty of Candour. Staff explained they were reminded of the process during unit meetings. We were told that openness, honesty and transparency were already embedded in the way investigations were carried out. Staff understood the term and spoke about being honest and open with people.
- Posters were seen displayed in staff areas explaining the Duty of Candour responsibilities.

Cleanliness, infection control and hygiene

- All the units we visited appeared very clean and tidy. The units varied in how they demonstrated equipment had been cleaned following use. In Chippenham and Trowbridge Birthing Centres they used stickers to show items had been cleaned and were ready for use. In Frome Birthing Centre stickers were not used. It was therefore difficult to assess whether equipment had been cleaned that day. For example we looked at a set of baby weighing scales in a birthing room. Although the item looked clean and a paper cover would be used before a baby was placed on the scales, a baby may still touch the weighing tray surface. At Frome Birthing Centre we also observed not all of the curtains had the last or expected cleaning dates recorded on them, nor were there records to show when they were last cleaned.
- The Care Quality Commissions Maternity Services Survey 2015 found the trust scored about the same as other trusts for cleanliness of the room or ward and how clean the toilets and bathrooms were.
- Staff were adhering to the trust's bare below the elbows policy in clinical areas. There were hand gel dispensers throughout the birthing units. We saw them being used regularly by staff.
- Cleaning regimes were in place and records maintained to show the cleaning of the birthing pools for example. Each birthing centre had the cleaning regime for their pool displayed in the room and staff had access to the relevant policies on the trusts intranet.
- We were told the trust did not provide birthing balls as the infection control team had said they were not able to be cleaned effectively. Women were able to bring in their own birthing balls. However, vinyl covered bean bags provided by the trust, were seen in each delivery room. They were kept on the floor and covered only with a clean sheet when not in use. This did not appear to be consistent advice. Since the inspection the trust have developed a standard operating procedure (SOP) in order to allow safe provision of birthing balls.
- Piped oxygen and wall mounted suction units at Frome Birthing Centre had tubing attached to them so they could be used as required. The staff told us they changed the tubing if it had been used. A different trust (Somerset Partnership Trust) owned the building and was responsible for maintenance and routine renewal of the tubing. We saw records from January and April 2016 that showed 'planned, preventative, maintenance' (PPM) checks had been carried out on the piped oxygen. There were no records available at the unit to show when the oxygen or suction tubing had last been changed either after use or as a routine procedure.

- Legionnaire testing on kitchen taps (not accessible to patients or visitors) at Chippenham Birthing Centre had resulted in the taps being put out of use until the required amount of clear samples of water had been received. The testing was the responsibility of the Great Western Trust who owned the building. Staff said the samples had been taken and the results awaited. The taps had been out of use for at least the three weeks the senior midwife had been working at the centre.
- Women who were at risk of methicillin-resistant staphylococcus aureus (MRSA) were screened during their ante natal period.
- At Frome Birthing centre we saw boxes stored on the floor which would have made effective cleaning of these areas difficult.

Environment and equipment

- Chippenham Birthing Centre, Frome Birthing Centre and Trowbridge Birthing Centre's were based in local community hospitals that were maintained by the trusts that owned them. There was stair or lift access to all floors. Access to delivery areas and inpatient facilities was by means of a keypad at all sites.
- There were some access issues to equipment at Trowbridge Birthing Centre which caused unnecessary delays. Access to the birthing unit at Trowbridge for midwives collecting equipment out of hours for use at a home delivery was impeded by two metal posts. This meant the midwife had to park their car, access the unit along a path that may not be well lit at night, collect their items and return to their car. This may take two or even three journeys. If the posts were not there the midwife could drive straight to the back door and park in a designated space, thus saving time which is always important when attending a home delivery.
- Community midwives based at the Royal United Hospital used a room adjacent to the Day Assessment Unit (DAU). The room was used for seeing women ante-natally and may involve appointments in the evening. The room was small and appeared cramped. Midwives were concerned because although there was a call bell in the room in the evening, the DAU was not manned and therefore there would be nobody to respond to the bell; this left some midwives feeling unsafe at times. There was also a designated space near the triage area used by the community midwives. The space had no door and lacked privacy. When this was bought to the attention of the trust they told us: staff members had access to a telephone at all times and for the majority of occasions, hospital based screening and antenatal clinics were running when the community midwives were carrying out ante natal checks in this room. Community staff had always been advised that should they be lone working in their room in the antenatal clinic area and there were no other staff working close by and they felt this posed a risk to themselves, they had the option to relocate to the delivery suite to complete their clinic. An extract from the Bath community teams 'safety briefing' from January 2016 indicated late shifts would be starting in February 2016 and which days screening and DAU clinics would be being carried out at the same time. The brief added that if DAU was closed staff were to let the Central Delivery Suite know they were working in their room alone.
- There was a range of medical equipment available to staff including blood pressure and pulse monitors and handheld sonicaid machines. Staff said if any piece of equipment became unserviceable it was quickly repaired or replaced.
- Improvements were required for the safe storage and access of some equipment. There was emergency adult and neonatal resuscitation equipment available at all of the birthing units. In Frome the resuscitation guidelines on the adult trolley were out of date. We pointed this out to staff and they were removed the same day. There were no updated guidelines in their place at the time of the inspection. None of the adult resuscitation trolleys were tamper proof meaning anybody could access the trolleys and remove or contaminate items. The units told us they were waiting for chains to secure the trolleys but although they had been ordered at least three weeks prior to the inspection, staff had no idea how long they would have to wait for them to be delivered.
- Adult and neonatal emergency resuscitation equipment was checked regularly in accordance with trust policy and a record maintained to show it had been checked. At Frome Birthing Centre the neonatal resuscitation trolley had been used prior to our visit but the plug used to recharge the machine had been broken. The midwife in charge had reported that the machine was not able to be charged and was assured somebody was on their way to fix it.
- Emergency evacuation equipment was available if required, to help women out of the birthing pool. Staff were trained in the use of the equipment and had

practised an evacuation in Trowbridge and Chippenham but not yet in Frome. Although a session had been booked it had been cancelled and was due to be rescheduled. There was not always enough space for a bed to be placed next to a birthing pool to move a patient onto in the case of an emergency. This meant women would have to be placed on the floor which would be undignified and difficult for staff to maintain safe care.

Medicines

- Medicines were not always managed safely. We found out of date medication at Trowbridge and Chippenham birthing centres. We pointed this out to the midwives on duty who ensured the drugs were removed. Midwives were responsible for checking the expiry dates of drugs and ensuring medication supplies were replenished as necessary.
- Medicines requiring refrigeration were correctly stored although the fridge temperature checks were not always recorded on a daily basis. One of the fridge temperature recording charts did not have safe minimum or maximum temperature levels indicated. This meant staff were possibly unaware of what the safe level was.
- Intravenous fluids were not always stored appropriately, for example, on resuscitation trolleys that were not securely locked and therefore accessible.
- There was some confusion about the use of oral ranitidine medicine prescribed or used for women who were being transferred to the acute hospital maternity unit. Midwives at two of the birth units told us it was used and a midwife at another unit said the use of this medicine was on hold whilst the policy and patient group directive was reviewed. There was similar uncertainty around the use of naloxone following a reaction to pethidine. However, it is noted that guidance on the use of these medicines has recently been circulated to staff (February 2016).
- Controlled drugs were stored appropriately in each area. We checked the controlled drugs registers and stocks of controlled drugs at each birthing centre and found them to be correct.

Records

- Women carried their hand-held records with them throughout their pregnancy and took them to each clinic appointment. These contained records of the progress of the pregnancy and detailed their choices around how and where they would like to have their baby. The women continued to hold the notes post-natally and took them to post-natal appointments where the health and progress of the women and baby would be recorded. We looked at two sets of completed records and found them to be detailed, well organised and completed appropriately including risk assessments. One woman we spoke with was having her ante-natal care from a different trust to that where she was having her baby. Her hand-held notes were completed at whichever site she was having her appointment.
- Patient records were stored securely at each birthing centre and in the community midwives office at the Royal United Hospital (RUH).
- There was no provision for the safe storage of community midwives diaries. The NMC (Midwives) Rules 2012, require midwives to ensure that 'all records relating to the care of the woman or baby must be kept securely for 25 years. This includes work diaries if they contain clinical information'. The Local Supervising Authorities (LSA) annual audit report for RUH was published in May 2015. One of the areas identified that required improvement was in relation to Midwives Rule 6: Records. This was due to no current system for the safe storage of community midwives diaries and no space for the storage of the diaries. The LSA report recommended supervisors monitored and reviewed safe storage of community midwives diaries. This issue was added to the maternity and gynaecology risk register in April 2015 with a completed date of May 2015. On speaking to a number of community midwives we found midwives continued to store diaries at their own homes or in unlocked drawers in offices. These could be accessed by many different people. We bought this to the attention of the directorate leads during the inspection who confirmed they thought work was ongoing to resolve the issue. They assured the inspection team they were going to look into the issue urgently. Following the inspection we received confirmation from the trust that they had taken the following actions:
  - Developed an action plan – and the Head of Division and the Director of Nursing and Midwifery received weekly updates on progress.
  - Immediately instigated a recall system for current midwives and those that had left the service since maternity transferred to the RUH in June 2014.

Requires improvement

Are services safe?

- Diaries were being logged, including those being recalled from the Birthing Centres' storage.
- Long term secure storage secured.
- A standard operating procedure (SOP) for collecting diaries in the future had been approved by the Women's and Children's Divisional Board.

Safeguarding

- Policies and procedures were in place regarding safeguarding adults and children. These provided guidance to staff on the actions to be taken where they suspected a safeguarding issue. Staff were able to access these via the trusts intranet.
- Staff we spoke with clearly understood the safeguarding process and knew who to report their concerns to and how to access the relevant documents to make a safeguarding referral. There was a safeguarding midwife who was available for advice. Staff spoke highly of the safeguarding staff and said they provided support and advice when required. A maternity safeguarding committee met every month and included band 7 midwives from community services.
- Staff had good working relationships with local mental health teams based in their local areas and with other professionals such as health visitors in the local community.
- Staff attended safeguarding training relevant to their role. All midwives were trained to level 3 and the maternity support workers to level 2.

Mandatory training

- Staff were required to complete a programme of mandatory training which varied according to the job role. They found it did not always cover aspects specific to midwifery led units such as evacuating a patient from the birthing pool. Training was often at the main acute hospital site and staff were given time to attend their training. Data showed that in February 2016, staff in the women and children's division were between 78% and 99% compliant with mandatory training.
- Additional mandatory obstetric emergency training was held throughout the trust. Staff said they had no problem accessing training online or face to face.

Assessing and responding to patient risk

- Individual risk assessments were completed at a women's first booking appointment and then reviewed throughout their pregnancy. This included family history, previous obstetric and medical history and screening for gestational diabetes and pre-eclampsia.
- Improvements were required to evidence which women were risk assessed as suitable for home births or delivery at a birth centre. The criteria for who could deliver their baby at a birth centre or at home was detailed in a policy document called 'Maternity Booking and Ante Natal Care Policy' that described the 'recommended pattern of care for all women' and the 'recommended pattern of care for high risk women'. Midwives, when asked, did not go straight to the document but did access information about who was suitable for a home delivery or a birthing centre delivery embedded in other guidance, which took some time to find. However, experienced midwives told us who they would accept for delivery at home or at a birthing centre and were very clear about how they came to that decision and who they would refer women to should they encounter any problems during pregnancy.
- Improvements were required to evidence what increased risks would require a woman to be transferred for consultant care and/or hospital delivery. The same applied for the criteria for when to transfer women to an acute unit as they or their baby were at risk. Midwives again told us clearly who would need to be transferred, but they were not able to quickly access the correct policy that supported their decision when asked to find it on the trust's intranet system..
- Frome Birthing Centre had 118 normal deliveries between April and September 2015. Forty-one per cent were primips (first time mums) and 59% were multips (second or subsequent pregnancy). There were 26 transfers (18%) into an acute hospital, 20 (77%) of these were primips (first pregnancies can be more unpredictable and women may require more monitoring) and 6 (23%) were multips. The main reason for transfer was delay in progress of labour.
- Midwives had mixed experiences of ambulance waiting times when they had called for women to be transferred. At times a midwife has had to wait for 45 minutes for an ambulance to arrive. When this happened midwives filled in an incident report and

escalated their concerns to senior staff at the time. We understood the trust were in discussions with the ambulance services about how obstetric emergencies needed to be managed.

- A number of midwives told us they worried when women who had been assessed as high risk still wanted to have their baby at home or in a birthing centre. They could not refuse as women were quick to explain they had a choice even though the risks had been explained to them. We saw completed notes that showed very detailed documentation throughout a woman's labour if they were considered to be at high risk. The Maternity Booking and Antenatal Care Policy stated 'Women who do not meet the booking criteria for their preferred choice of place of birth must have their decisions respected even when it is contrary to the views of the healthcare professional. For further support and discussion the women can be referred to a Supervisor of Midwives where an individualised care plan will be agreed and documented'.
- Women in the community or at a birth centre were monitored before, during and after the birth to assess their health and wellbeing of their baby. We saw that comprehensive records were maintained that included an obstetric early warning score system (prompts escalation to an appropriate practitioner). Midwives were trained and skilled in supporting women who opted out of any monitoring for themselves or their babies.
- The patient safety team were aware of all the serious incidents reported, the outcome of investigations and how any learning was to be put into practice and monitored for effectiveness. They worked closely with the audit specialist midwife.
- The birthing centres had a folder containing information of actions to take in the event of an adverse incident such as fire, water failure or closure of the unit. Staff were aware of the folders and how to access them.

Midwifery staffing

- All women who attended birthing centres or had a home delivery received one to one care during their labour and delivery.
- Frome Birthing Centre had one midwife vacancy to which they were having trouble recruiting. There was no identified reason why recruitment was difficult in this area. They used existing staff working extra hours to cover the vacant shifts. The other two birthing centres reported vacancies but they had recruited to the posts.
- All of the birthing centres and the RUH community midwives provided an on-call system at night. Staff reported that due to the introduction of the working time directive (WTD) in February 2016, their on call shifts were effectively on their days off to ensure they did not exceed the daily recommended working hours. In order to comply with the WTD the on-call system had been split so a midwife would be on call from 8pm until 10pm, or from 10pm until 8am the next morning. Staff at Frome Birthing Centre in particular felt the system was not workable in the long term. Midwives felt like they never got a full day off due to the frequency of the on-call shifts. The issue of non-compliance with the WTD was placed on the maternity and gynaecology risk register in June 2014. The register states ongoing meetings with staff groups to map progress. The trust responded with the following comments: The introduction of the working time directive (WTD) was on the basis of safety to ensure that staff do not exceed daily recommended working hours. On-call commitments are part of the off duty roster, which is planned in advance and takes into consideration flexible requests by staff and also allows the ability to change shifts if required.The overnight on-call shift pattern runs until 8am and in some circumstances, the next period may be an off duty period but this is a standard requirement of undertaking on-call for all staff groups. On-call is part of the community midwife contract and an expectation that they will participate in the on-call rota unless there are exceptional reasons to make them exempt from this.This new way of working was piloted with Chippenham birth centre and was signed off as workable by the Midwife team.
- Midwifery and maternity care assistant staffing levels were under review in line with NICE guidance. Senior midwives said the publication of the National Maternity Review; A Five Year Forward View for maternity care in March 2016, would influence future staffing levels and looked forward to helping community services understand the report and implement recommendations going forward.
- Midwives said that a second midwife was always available for deliveries in the birthing centres or at home, overnight or at weekends. They said however, the

midwife sometimes had to come from a long distance and this caused anxiety to the midwife on duty and the second midwife attending the birth. This had been raised as an issue and was on the directorate risk register.

- Chippenham Birthing Centre had three delivery rooms, four post-natal beds and two assessment beds that could be used for inpatients if necessary. The centre also ran ante-natal clinics, post-natal clinics and parent craft sessions. Staffing levels meant that all activities could be covered during the day with two midwives and a maternity care assistant on duty overnight, with support from the on-call system if necessary.
- Frome Birthing Centre had three delivery rooms and one multi-function room. The unit did not have any inpatient beds but held ante-natal clinics and post-natal clinics and assessed women who thought they may be in labour. There was one midwife and a maternity care assistant on duty at all times with support from midwives on the on-call rota. The senior midwife told us post-natal appointments were sometimes made for women when they thought the unit may be quieter in between their other work. This meant appointments were sometimes made because of staffing levels and not always to suit the women. However there had not been any complaints made about times of appointments. We saw two women arrive for their post-natal appointments who were taken straight into a consulting room without having to wait.
- Trowbridge Birthing Centre had two delivery rooms and one multi-function room where women in early labour or who needed assessment could stay. There were four midwives and two maternity care assistants on duty during the day to cover the deliveries, ante and post-natal clinics, ward attenders and home visits. There were two midwives and one maternity care assistant on duty on a late shift and overnight. The on-call system across the whole patch was co-ordinated from Trowbridge Birthing Centre.
- All the centres had a mix of band 6 and 7 midwives who were experienced in providing midwifery led care and support.
- Midwives with specialist interests were available to provide support with public health initiatives, infant feeding, young families and safeguarding. There was a handover between staff at each shift change. The handovers included a daily safety brief covering subjects local to the birthing centres or community and also trust wide issues. Staff had to sign to say they had listened to the safety brief at each shift. If a staff member was not able to attend the shift handover, the safety brief was printed out for them to read. Senior maternity staff told us they had learnt from national enquiries regarding the risks of staff working solely in one place (Morecombe Bay).This has led to the development of rotational posts (between clinical areas) and the employment of new maternity staff to work within the service rather than a specified area.

Medical staffing

- There was no medical cover provided either for home deliveries or at the birthing centres as care was provided to low risk women and was midwifery led.

Other staff

- Maternity support workers worked throughout the community maternity services providing support in the birthing centres, ante and post-natal clinics and home visits. These staff provided support with infant feeding or routine screening blood tests.
- Sonographers worked in birthing centre ante-natal clinics providing dating scans. They were managed by the diagnostics division.
- Ward clerks/administrative support staff worked at all the birthing centres providing support with documentation, taking and making telephone calls and greeting patients.

Major incident awareness and training

- The buildings where the birthing centres were based did not all belong to Royal United Hospitals NHS Foundation Trust. Staff at each centre were aware of who was responsible for their building in the event of any incidents with utility supply or infrastructure of the building. Staff were aware of evacuation plans for each site.
- Staff were aware of how to access the trusts major incident plan.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We judged patients experienced good outcomes as they received effective care, treatment and support because:

- There was an ongoing audit programme. There were a number of national and local audits ongoing during the inspection.
- There were good clinical outcomes for women using the community maternity services.
- Infant feeding support and advice was available to women at home or at the birthing units once they had given birth.
- Midwifery practice was reviewed to maintain clinical standards. There was good and embedded multidisciplinary working both internally and externally.

However, there were some areas which required improvement:

- Whilst the birth environment was supportive of active birth, it could be enhanced with additional equipment to support labour.

Evidence-based care and treatment

- There was a trust wide audit team who reviewed guidelines, policies and procedures on a regular basis. There was a maternity specific audit midwife who was involved in the review of maternity specific guidance, policies and procedures. This ensured documents were up to date and in line with new guidance. These included a range of National Institute for Heath and Care Excellence (NICE) guidelines, Women received care in line with NICE quality standards for example: 22 (for routine ante-natal care), 37 (for post-natal care) and 98 (for improving maternal and child nutrition).
- Staff had access to guidelines, policies and procedures via the trust intranet.
- There was an ongoing audit programme. There were a number of national and local audits ongoing during the inspection. Staff were engaged with audits. Summaries of the audit results were shared with staff once completed.

Pain relief

- Birthing pools were provided at each birthing unit, apart from Trowbridge which was out of action during our inspection. Staff did not know how long the pool was expected to be out of use.
- Midwives provided pain relief in the birthing centres or at home in the form of nitrous oxide gas or pethidine.
- Whilst all the birthing rooms had access to birthing pools, bean bags and double beds, there was no additional equipment to help with pain relief and promote natural birth such as use of massage or aromatherapy, birthing balls, ropes/slings suspended from the ceiling, mats or stools. Good practice endorsed by the Royal College of Midwives encourages women to understand and explore different positions for giving birth, a number of which included using a birthing ball or a mat. The trust told us families were invited to bring in additional equipment, music and lighting to support their active birth expereince.

Nutrition and hydration

- There were meals available for inpatients and snacks and drinks available at all times for women and their labour partners. Specialist diets could be catered for.
- Infant feeding support and advice was available to women at home or at the birthing units once they had given birth. Staff could ask the trust infant feeding co-ordinator for advice and support if necessary.
- The maternity services had level three accreditation with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed.

Patient outcomes

- The maternity performance dashboard recorded activity trust wide to collect data about the outcomes for women and babies such as post-partum haemorrhage, number of inductions and number of elective and emergency caesarean sections.
- Between April and September 2015 there had been three months with no unexpected admissions to the Neonatal Intensive Care Unit (NICU) with the other months averaging 6.5% which was within the trust

tolerances. There had been no unplanned maternal admissions to critical care (ITU) in the same time period for women who had started to labour in community settings.

- Between September 2015 and February 2016 the percentage of planned community or home births resulting in transfer to the delivery suite on the Princess Anne wing at Royal United Hospital Bath was between 16% and 24%. All unplanned transfers were investigated to identify themes. Most of the transfers were due to unpredictable issues such as failure to progress during the second stage of labour and requests for an epidural.
- The percentage of women transferred from home to hospital from April 2015 to February 2016 ranged from 16% to 24%. There were no national standards to benchmark transfer rates but each case was reviewed for themes or any learning that could be taken forward.
- In September 2015 data from the Regional Strategic Network Dashboard showed free-standing midwifery led units accounted for 19.5% of all birth episodes for the trust. This was higher (better) than the regional average of 5.3%.
- Women were encouraged to breastfeed. Data showed the trust had better than average uptake of breastfeeding. Between September 2015 and February 2015 initiating breastfeeding was between 73.5% and 86%. The National average of women starting breastfeeding was 74%.

Competent staff

- A supervisor of midwives is a midwife who has been qualified as a midwife for at least three years and has completed additional training in midwifery supervision. By law midwives must have a named supervisor of midwives who they should meet at least annually. The ratio of supervisor of midwives (SOM) to midwives was 1:13. This exceeded the recommended ratio of 1:15 according to the Midwifery Rules and Standards (rule 12 Nursing and Midwifery Council 2014). SOM's told us they had time to provide support and guidance to their allocated midwives and were able to spend time with them. Midwives told us they had access to their SOM's and found them to be supportive and approachable. There was a SOM on-call overnight and we were told they came in to the units to provide support if necessary.
- Midwifery practice was reviewed to maintain clinical standards. The Local Supervising Authority (LSA) completed an annual assessment of the competencies of the trusts supervisors of midwives. The most recent LSA report was from March 2015. A further LSA assessment had taken place but the report had not yet been shared with the trust.
- A number of midwives had undertaken extra training to enable them to carry out examinations of the new born baby at home. The baby examination is carried out as part of the Newborn and Infant Physical Examination (NIPE) screening programme and must be done within 72 hours of birth.
- Not all staff were supported to have an annual appraisal. Rates in the women and children's division between April and October 2015 were on average 68% complete. This was below the trust target of 90%. Trowbridge Birthing centre was recognised as a 'hot spot' area with a reduced rate of compliance at 68%. Birthing Centre senior staff said appraisals were a high priority and staff were being given dates for their appraisals and time was built into the rota to ensure they could attend their session.
- As part of their six week induction period staff spent time at the birthing centres as well as the consultant led maternity unit and neonatal intensive care. This helped staff to be able to work in all clinical areas.

Multidisciplinary working

- Staff at all levels spoke very highly of the multidisciplinary working both internally and externally. Midwives in the birthing centres and community midwives spoke of good working relations with the obstetric and maternity staff at the acute hospital site. They described some discussions about the care of women and their babies and felt this was healthy professional challenge.
- Staff spoke of working well with external providers such as other local acute hospitals in the region when needing to transfer a woman or baby to their service, local GP's and local authority safeguarding teams.
- There was multidisciplinary attendance at governance and policy groups that included midwives from birthing units and the community.
- Specialist midwives were valued throughout the maternity services. Other specialist midwives, for example screening midwives and safeguarding midwives were accessed on occasions and staff appreciated the support they gave when required.

Good

Are services effective?

- There was a handover between staff at each shift change. If as a result of the handover other professional disciplines needed to be contacted staff were confident to do so and described good working relations.

Seven-day services

- Services at the birthing centres and the provision of home deliveries were available 24 hours a day seven days a week.
- There was no medical cover provided either for home deliveries or at the birthing centres as would be expected, but staff could access medical support if necessary by contacting the RUH.

Access to information

- Women carried hand held records, completed at every appointment attended by whichever health professional they were seeing. The notes informed health professionals and the woman about how her pregnancy was progressing. Women took their record booklet home on discharge from the birthing centres to ensure the community midwives had all the information required to carry on the care and support. If women forgot to bring their records to appointments notes could be made on the computer system to be added to the records at a later date.
- Community midwives were contacted daily to inform them of who was going home from RUH or who had been admitted to the service that the birthing centres or community midwives may be expecting to see.
- Administrative staff and maternity care assistants ensured patient records were available for clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records we reviewed showed staff gained appropriate consent for procedures. We saw details of discussions that had taken place prior to consent being given. We saw sets of blank records with consent forms for procedures and explanations of why consent was needed. Potential risks were detailed on the forms.
- Staff had an understanding of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Records showed compliance with the trusts mandatory training on this subject was between 78% and 99%, against the trust target of 90%.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We judged caring in community maternity services to be good because:

- Women received care and support from experienced midwives who were kind and compassionate and maintained women's privacy and dignity.
- Women told us they felt involved in their care and were treated with respect.
- Feedback via the NHS Friends and Family Test from women and their families was mostly positive. The trust also used other ways of gaining feedback from people who had used their services including Birth Reflections, social media forums and 'In Your Shoes' listening events.

However there were some areas that required improvement:

- Improvements were required to increase the number of patients participating in the NHS Friends and Family Test.

Compassionate care

- During the summer of 2015, CQC sent questionnaires to all women who gave birth in February 2015 (and January 2015 at smaller trusts). This was to find out about their experiences of maternity care and treatment. The trust scored about the same as other trusts for the majority of questions. The service scored better on two questions. These related to having confidence and trust in staff during labour and birth and being treated with dignity and respect.
- During the inspection we heard staff treating patients and their relatives with respect and kindness. Women we spoke with told us staff had been "informative", "professional" and "supportive".
- Responses to the Friends and Family Test for post natal community provision (percentage of people who would recommend the service), between December 2014 to November 2015, were above the England average for eight of the 12 months with 100% for five of those months. The lowest score was 94% in January 2015.

Understanding and involvement of patients and those close to them

- The CQC survey of women's experiences of maternity services 2015 found that the trust scored about the same as other trusts when involving a partner or someone close to the woman during labour and birth.
- The birthing centres carried out 'In Your Shoes' listening events from September 2015. This is a rolling programme of events. These asked families about their experiences of using the maternity services and what their key priorities were for improvements to the maternity services. Feedback from Chippenham Birthing Centre in December 2015 said families valued 'individualised care', information and explanations and the support available. They did not value 'poor communication', 'negative staff attitudes' or when staff were 'dismissive of concerns'. Key priorities were offer individual, personalised care and offer more support in early pregnancy. Feedback from Trowbridge Birthing Centre in November 2015 said families valued 'continuity of care', 'feeling supported' and 'feeling safe'. They did not value 'poor communication', 'not feeling listened to' and 'lack of breastfeeding support'. Key priorities were continuity of care and treating women and their families with respect and to support personal choice. Each unit was evaluating the responses and would be putting together a plan of how to continue to good work alongside considering how improvements could be made.
- Three women who had used the maternity services we spoke with were very positive about their experiences and information provided to them throughout their pregnancy, labour and post-natally. They felt fully informed and empowered to make choices about where and how to have their baby.
- We saw patients attending maternity clinics were able to bring somebody along with them and staff asked if they were happy to have the person come into the consulting room with them.
- Women and their relatives we spoke with said they were provided with information and had their treatment options discussed with them. They said they felt able to ask questions and got clear answers.
- We observed a tour taking place during our inspection. There was a small group of women and their partners. They were able to see all areas of the centre and

facilities available. Midwives told us they could show people round individually or in groups depending on how busy they were. The midwife showing them round was enthusiastic and able to answer questions confidently. We saw that a parent craft class was taking place at one birthing centre. It was well attended and people taking part had enjoyed the session.

Emotional support

- The midwifery led Birth Reflections Service had been running for over five years. On the trust website the service stated their aims to; help women explore their birth experience by providing an opportunity to gain answers to questions, and to help Maternity Services to identify areas where we can improve our care provision. Clinics were run from Chippenham Birthing Centre and Royal United Hospital. Over 120 women a year, on average, were seen in the clinics.
- Counselling services were available if required to women who attended the birthing centres. They were provided by different organisations depending in which county the birthing centre was located.
- The infant feeding midwife or maternity care assistant provided practical and emotional help and guidance to women having difficulties feeding their baby. If they were not available in person they could provide advice to midwives over the telephone who could then help the women.
- Midwives and maternity support workers who visited women and their families at home and worked in the birthing centres were usually experienced midwives who were able to provide support and guidance in many areas both ante and post-natally.
- We observed emotional support provided to women. We heard midwives supporting women on the telephone. Concerns were identified and reassuring responses were given. Women were not made to feel rushed even when staff were busy in the unit. Women were encouraged to call back at any time if they continued to have concerns.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We judged the responsiveness of the community maternity services as good because:

- Systems were in place to support access and flow through the birth centres.
- Feedback from women who used the service was the same as, or better than other trusts nationally.
- There was easily accessible information about pregnancy and birth available to women in the units or via the trust website.
- There was evidence of learning from complaints and sharing that learning throughout the community services.

Service planning and delivery to meet the needs of local people

- The Maternity Services Liaison Committee, made up of people who had used maternity services, maternity staff and commissioners, met regularly to help influence how services were designed to meet the needs of local women and their families. Minutes showed issues discussed included proposals for new clinical pathways and discussions about recent national investigations (Morecombe Bay).
- The midwifery led Birth Reflections Service had been running for over five years. On the trust website the service stated one of their aims was; to help Maternity Services to identify areas where we can improve our care provision.
- Partners were able to stay with women during labour and birth. There was limited space for partners to stay overnight in post-natal areas with beds. However, partners could stay in delivery rooms or the multi-function rooms where women who had delivered overnight might want to stay until the morning.
- The trusts own website had links to local resources such as the clinical effectiveness forum, positive birth forum and 'in your shoes'.

Access and flow

- Systems were in place to support access and flow through the birth centres. Women who were booked to have their babies at one of the birthing centres could ring their centre if they had any concerns, or if they were in early labour. Women were asked to attend the unit to be examined. There were multi-function rooms at each site where women could be triaged and examined as necessary.
- The birthing centres had never been closed because they were unable to meet demand. Community midwives were aware of women who had chosen to deliver their babies at home and when their babies were expected. Local teams ensured midwives in neighbouring teams were aware of the chance they may have to attend a home birth and the location.
- A number of community based midwives were able to carry out newborn screening checks. These had to be carried out within 72 hours of birth. This meant women who were able to go home from the birthing centres and RUH could have the checks carried out in their own homes. This helped flow throughout the hospital site at times.
- Women who had booked to have a water birth were made aware that if the pool was in use when they presented at their birthing unit, they may not be able to have use of the pool. Staff said women were very accepting of this and it had never caused any problems.
- When the birthing centres became busy or there was a home delivery (on occasions, more than one at the same time) there was an on-call system managed by Trowbridge Birthing Centre. This ensured midwives were called in and redeployed as necessary.
- Staff at the birthing centres were able to supply frequently dispensed medicines from the ward for women to take home, as agreed in trust patient group directives. This meant women did not have to wait very long to go home once they had been discharged.

Meeting people's individual needs

- Staff had access to translation and interpretation services, this included British Sign language and lip-speakers for people with hearing difficulty. Staff said they did not have to use the services very often but when they did the systems had been effective and quick to respond.

Good

Are services responsive to people's needs?

- There were a range of leaflets available on the trust's website in a number of languages and available in easy read format.
- There were a range of leaflets available at the birthing units about feeding choices.
- Women with learning disabilities could have their ante-natal care and support from the birth centres, and if assessed as low risk could deliver their baby at their local unit. Midwives described occasions when they had looked after women with a learning disability and how the local health professionals, such as the learning disability services and health visitors, worked together to provide support from ante-natal booking through to the post-natal period.
- There was a midwifery led public health service called BLOOM available to support women who had issues with alcohol and/or drug misuse, were subject to domestic violence, teenage pregnancy or needed help to stop smoking. There was also a specialist screening midwife and an infant feeding midwife based at the RUH. They were available to provide support and advice to colleagues in the community.
- The CQC Survey of Women's Experiences of Maternity Services in 2015 found the trust was 'about the same as other trusts' in speaking to women in a way that could be understood and enabling women to move around when in labour and choose the position that made them most comfortable. They scored better than average for women being treated with respect and dignity and for having confidence and trust in the staff caring for them during labour and birth.
- Feedback from the Birth Reflections Service provided to help women explore their birth experience and/or identify areas where services can be improved, was fed back to maternity services on a quarterly basis and has helped to improve services. For example as a result of feedback partners have been able to stay on the ward areas overnight.
- There was access to leaflets about maternity subjects available in clinics, on wards and on the trust's website. Trowbridge Birthing Centre had their leaflets in a folder in the ante-natal clinic following feedback from women who said they preferred that to them being displayed in racks on the walls. Clinic waiting rooms had toys and magazines available for patients and their children whilst waiting for their appointment.
- Call bells were available in each delivery room and at each inpatient bed area.

Learning from complaints and concerns

- Information about how to make a complaint was displayed in the birthing centres. The trust website had information about how to make a complaint and a leaflet detailing the complaints process available to download. Women we spoke to said they would raise any concerns with staff at the respective birthing centre or via their surgery if it involved community midwives.
- Each birthing centre or community team was made aware of any formal complaints about their service. The sister of the unit was asked to investigate unless it involved them in the complaint in which case a sister from another unit would investigate. Any actions or learning from the complaint would be recorded and shared with the birthing centre staff and then disseminated to the other birthing units and community teams and if relevant, to the RUH staff. This could be in person at meetings or via trust wide newsletters. Divisional leads and governance staff reviewed the ongoing complaints on a monthly basis to ensure the process was being followed.
- Senior staff said if they received a complaint they would contact the person concerned to discuss personally with them their expectations from the process and expected timescales of the investigation.
- Patients were encouraged to complete the NHS Friends and Family Test to provide feedback about their experiences. Staff were encouraged to share their views on the service and any improvements that could be made.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We judged the leadership of the community maternity services as good because:

- There were robust risk management and governance systems and processes in place. Staff felt engaged in the processes and received good support from the risk management team. Regular meetings were held at birthing units and in community teams with information flowing to directorate and trust level and back again.
- There were systems to share information and learning.
- There was strong interim leadership in place. A positive culture was evident at all of the services we visited.

However there were some areas that required improvement:

- There were high sickness rates across the trust. Support systems were being introduced to help improve the rates.

Vision and strategy for this service

- Staff were clear that women and their families were at the heart of everything they did. They were very pleased they were now permanently employed by the Royal United hospital as they had been with several trusts over the preceding few years. Staff said this meant they could now look to developing their services, safe in the knowledge they would be able to see plans through.
- The NHS England review of maternity services was published in March 2016. Staff said this would help maternity services decide on their vision for the future and how they could continue to improve services provided. The report set out current maternity provision and how it could be developed to meet the changing needs of women and their families.
- Staff had started to rotate around the birthing units and into the maternity unit at RUH to ensure competencies were maintained and staff were not working in silos and thereby developing their own culture.

Governance, risk management and quality measurement

- There were trust wide governance and risk management systems in place. We saw risk registers for maternity services that included audit information and updates for each entry on the register to show they were being actively managed.
- Senior staff had an understanding of the risks associated with each birthing centre or community team. One unit sister said if they had concerns they could ask the audit team to design a bespoke audit for their unit. There were no examples of where this had happened recently. Staff said they felt audits were useful to improve practice and were happy to be involved as they received feedback, which showed areas of good practice and areas where they could improve.
- There were risk assessments completed for lone working arrangements in the community.
- A monthly maternity and gynaecology operational report was produced by the women and children's divisional management team. These provided quality and risk assurance information to the trust's operational and quality leads. We reviewed the reports dated January and February 2016. Incidents were categorised and detailed according to the level of impact on patient care. Serious incidents were summarised, including what stage investigations were at and anticipated completion dates. The number of open risks was identified by specialty and significance. For example, the operational report dated February 2016 showed 58 open risks. Risks assessed as being significant had detailed updates by each summary. These included what actions were required to mitigate risks, anticipated completion dates for actions and which staff had responsibility for actions.

Leadership of service

- Staff we spoke with told us of excellent interim management for the birthing centres and community maternity services. They described them as both supportive and approachable. Senior staff were present at the birthing centres during the inspection both to support staff and add detail from a divisional angle where appropriate.

Good

Are services well-led?

- Staff said they had felt informed about the acquisition, in June 2014, of maternity services by Royal United Hospitals Bath from Great Western Hospitals NHS Trust. Although they had worked within the RUH they had not been clear about their future for several years. They said they had felt welcomed into the Royal United trust and were aware of the organisational structure, and felt informed by the directorate leads.
- Duty rotas showed there was always a supervisor of midwives available.
- The interim head of midwifery was supported by an acting community matron with senior staff on duty at the birthing centres and in community teams each day.
- When being shown around the units it was clear all staff knew the interim senior team and found them approachable.
- A quarterly patient safety visit was carried out to the birth centres by board members/executives. The director of nursing had visited one of the birth centres and held an informal group meeting with staff to discuss any issues.

Culture within the service

- Staff were very positive about working for the trust as a whole. Midwives were proud of the midwifery led care and support they offered to women and their families.
- Staff described an open culture in which they were encouraged and supported to report incidents. Learning from incidents was described by all levels of staff and seen as a positive result of reporting incidents.
- A student midwife told us they felt supported and encouraged by staff during their placements with them.
- A member of staff reported that they had come to the service as a volunteer and applied for a post because she had felt so well supported by other members of staff. She also said she would recommend the service and happily use it herself.
- Another member of staff said there was good team working and colleagues were supportive.

Public engagement.

- Frome Birthing Unit reported they received funding from a local charity and used this to buy equipment such as settees and televisions to improve the patient experience.
- Social media pages, trust wide and for Trowbridge Birthing Centre, had been developed to engage women and seek their feedback around service improvements with opportunities to take part in local and national surveys. The page was monitored regularly. There had been over 800 'likes' for the Trowbridge Birthing Centre page.

Staff engagement

- We were told and saw minutes of the monthly birthing centre meetings. They enabled staff to come together to discuss learning points and required actions, good practice and staffing levels. Information from these meetings was then cascaded to each birthing centre if relevant, such as local learning points.
- Newsletters and update emails from the trust were said to be very informative and regular.

Innovation, improvement and sustainability

- The sister at Trowbridge Birthing Centre described the recently introduced 'long day clinic structure'. This meant staff worked form 8am until 9pm, this offered evening antenatal clinic and booking appointments. This was proving popular with women who were working and found it easier to attend after work. There was also protected time built into the structure to allow staff to update their e-learning and read trust wide and local newsletters and bulletins.
- To address the high sickness rates across the trust we heard about plans to begin to offer resilience training for staff and to review the support systems in place for staff to access. The sickness rates were attributed to long term sickness, increased pressure on staff covering sickness and vacancies.
- We met with the midwives who were running the SHINE In Pregnancy; Healthy Lifestyle Programme. Midwives could refer women to the SHINE team to see if they would be suitable for one of the programmes. The February 2016 update leaflet stated the programme had been designed to be part of the pregnancy pathway. This was to help with steady weight gain during pregnancy, safe exercise and nutrition and anxiety and stress management. Smoking cessation appointments with the SHINE team were also running at Chippenham and Trowbridge Birthing Centres. It was too soon to evaluate the success of the SHINE programme during the inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The trust did not provide secure facilities for storage of community midwives diaries once they were completed.