

North Cumbria University Hospitals NHS Trust

Penrith HospitalPenrith Hospital

Quality Report

Bridge Lane

Penrith

Cumbria

CA11 8HX

Tel: 01768 245555

Website: [www.cumbriapartnership.nhs.uk/
penrith-community-hospital.htm](http://www.cumbriapartnership.nhs.uk/penrith-community-hospital.htm)

Date of inspection visit: 02/05/2014

Date of publication: 07/10/2014

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

Ratings

Overall rating for this hospital

Good



Maternity and family planning

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the birthing centre at Penrith Hospital on 2 May 2014 as part of our comprehensive inspection of the acute core services of North Cumbria University Hospitals NHS Trust. Although our Intelligent Monitoring data identified the trust as being high risk, the trust's birthing centre had not been identified as a risk.

We rated the maternity services at the birthing centre as good.

Our key findings were as follows:

- The birthing centre at Penrith was well run overall. However, we found it lacked an articulated strategic vision.
- The centre was not being used to its full capacity. The data we saw showed that out of 60 women booked to deliver at the centre, following a risk assessment at 36 weeks only 23 women actually delivered their babies there. Seven women required a transfer during labour and seven were unable to deliver at the centre because of a shortage of staff.
- The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. Managers were reviewing all transfers from the centre to the Cumberland Infirmary at Carlisle to identify indicators and trends for the reasons why women could not deliver at the centre. This demonstrates that they were working to understand and predict safe deliveries at the centre.
- Arrangements were in place to ensure a sufficient number of staff to provide safe care. The service had the standard ratio of one midwife to 28 hospital births, which is in line with national standards. If staffing levels were compromised then arrangements were made to transfer women to other centres so that safe staffing ratios were maintained; 100% of women had one-to-one care in established labour and there were sufficient numbers of supervisors of midwives within the birthing centre.
- The unit was clean and tidy and each room was stocked with appropriate personal protective equipment for staff.
- After a recent internal review of the midwifery service, the trust introduced a midwifery governance lead, which had improved the approach to governance and monitoring clinical practice. Although the specialist midwife roles had been welcomed, the clinical lead roles and business unit manager roles were not yet fully embedded. This meant that staff were not clear about roles and responsibilities.
- We found that maternity services were delivered by committed and compassionate staff who treated patients with dignity and respect. All the people we spoke with were very positive and passionate about the service and about the care they had received.

The trust needs to make improvements in areas of poor practice.

Importantly, the trust should:

- Ensure the quality of information to improve the support for women who wish to complain. We found that although some complaint leaflets were available, information on both the role and contact details of the Care Quality Commission was out of date and inaccurate, and the leaflets did not clearly direct people to the Public Health Service Ombudsman.
- Ensure there is a service level agreement with the host trust to identify expectations about servicing and access to emergency continuity plans.
- Develop a local risk register for the centre to underpin the service risk register and ensure local risks are recorded, mitigated and escalated appropriately. Although we did note that the service was reviewing all transfers to the Cumberland Infirmary to gain assurance that women give birth in an appropriate setting.
- Clarify the governance structure, as the Maternity Services Liaison Committee had not met for two years.
- Clarify a leadership role with a clear remit to promote 'normality' in child birth as supported by the Royal College of Midwives Campaign for Normal Birth and the National Childbirth Trust Birth Policy.

Summary of findings

- Consider using information technology to improve the effectiveness of data flows. We were informed that the centre had recently received approval to introduce the IT data systems needed to help develop innovation and improvements.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Maternity and family planning

Rating

Good



Why have we given this rating?

The Birthing Centre at Penrith was well run overall. The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. The trust provided information that outlined how it calculated staffing levels, and arrangements were in place to ensure a sufficient number of staff to provide safe care. The service had the standard ratio of one midwife to 28 hospital births. This is in line with national guidance.

We found that maternity services were delivered by committed and compassionate staff who treated patients with dignity and respect. All the people we spoke with were very positive and passionate about the service and about the care they had received.

Good 

Penrith HospitalPenrith Hospital

Detailed findings

Services we looked at

Maternity and family planning

Contents

Detailed findings from this inspection

	Page
Background to Penrith Hospital	6
Our inspection team	6
How we carried out this inspection	6
Facts and data about Penrith Hospital	7
Areas for improvement	17

Detailed findings

Background to Penrith Hospital

We only inspected the midwifery-led birthing centre at Penrith Community Hospital. This was part of the comprehensive inspection of North Cumbria University Hospitals NHS Trust. The midwifery-led birthing centre

aims to provide an alternative place to give birth to local mothers deemed as low risk pregnancies. The centre can accommodate one mother in labour and provides a birthing pool and bed room.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector for Hospitals in the North

Head of Hospital Inspections: Ann Ford, Head of Hospital Inspection in the North West.

The team included a CQC inspector and two specialists including a Head of Midwifery and supervisor of midwives and a consultant Obstetrician & Gynaecologist.

How we carried out this inspection

We carried out the inspection on 2 May 2014 as part of the comprehensive inspection of North Cumbria University Hospitals NHS Trust. Before the inspection we reviewed the National Maternity Indicators that demonstrated the trust's performance in maternity services.

We inspected the Birthing Centre at Penrith Community Hospital, including the birthing room and clinic facilities. We spoke to five members of staff, and three patients and relatives.

We held listening events at both Carlisle and Whitehaven for members of the public to talk to us about their experiences of this and other services.

We also received a number of responses about the centre through our comment cards as part of the inspection. We gathered further information from data that we asked the trust to provide. We reviewed information regarding the trust's internal quality assurance and compared its performance against national data.

Detailed findings

Facts and data about Penrith Hospital

The centre had 23 births in 2013, and had recently been part of a trust wide review of maternity services provided by North Cumbria University Hospitals NHS Trust.

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and family planning	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Maternity and family planning

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

Information about the service

The birthing centre is based on the ground floor of the Penrith Community Hospital site, with secure access to the centre. The centre offers a midwifery-led service and is primarily used as a birthing centre.

The birthing centre is fully equipped with a well maintained birthing pool in pleasant surroundings to offer a relaxed environment for childbirth. It also provides access to clinics for both antenatal and post natal care for the local community. The service also acts as a base for community midwifery services providing antenatal care, home birth and post natal care.

The service is managed through the North Cumbria University Hospital emergency surgical and elective care business unit and was led by a Clinical director with a Head of Midwifery professional lead.

The centre had 23 births in 2013 and had recently been part of a trust wide review of maternity services.

Summary of findings

We found that the service lacked an articulated strategic vision.

The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. The introduction of a midwifery governance lead had improved the approach to governance and how it monitored clinical practice. The specialist midwife roles had been welcomed but the clinical lead roles were not yet fully embedded. This resulted in a lack of clarity about roles and responsibilities.

The trust provided information that outlined how it calculated staffing levels, and arrangements were in place to ensure a sufficient number of staff to provide safe care. This was in line with national standards.

We found that maternity services were delivered by committed and compassionate staff who treated patients with dignity and respect. All the people we spoke with were very positive and passionate about the service and about the care they had received.

However, we found that the centre was not being used to its full capacity. The data we saw showed that 60 women were booked to give birth at Penrith, but following a risk assessment at 36 weeks only 23 actually delivered at the centre. Seven women required a transfer during labour and seven were unable to deliver at the centre because of staffing issues.

Maternity and family planning

Are maternity and family planning services safe?

Good



The maternity service at Penrith was safe overall. The birthing centre was clean and all staff observed control of infection and hand hygiene practices. Equipment was fit for purpose and well maintained. Medicines, including those for pain relief, were safely stored and administered. Accurate records demonstrated that staff sought consent to care and treatment appropriately, and that care was delivered by competent staff.

The service had identified risks, which were collated within the wider service risks at the Cumberland Infirmary location and it was monitoring its own performance against national and local maternity indicators.

There were systems and process in place to minimise risks within the birthing centre and staff were very clear that the care they provided was for women with low risk pregnancies. However, in the last year 4.2% of women needed to be transferred to Carlisle, a journey of up to 30 minutes. This indicated a potential risk to labouring women if they had to transfer to another location for medical assistance.

The service was reviewing all these transfers from the centre to Cumberland Infirmary to look for indicators and trends for reasons why it could not offer birth at the centre for some women. This demonstrates that it was working to predict safe deliveries for the centre.

Incidents

- The service had reviewed and strengthened its systems for reporting incidents and near misses across the whole service. Identified incidents were captured on the electronic incident reporting system. The birthing centre did not report its risks separately but as part of the wider trust maternity service. It had access to the trust's maternity governance group, which met monthly and reviewed all incidents.
- Staff could describe the process for reporting incidents and were confident and competent in doing so.

- The data from the trust showed that the service had not reported any 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented).
- The service had developed an integrated governance action plan to monitor all complaints, learning from incidents and audits against compliance with Royal College of Obstetricians and Gynaecologists Guidelines (RCOG), relevant National Institute for Health and Care Excellence (NICE) guidance and NHS Litigation Authority maternity standards. Feedback from incidents was shared and we saw examples of learning from incidents being applied and implemented, such as improvements to communication and discharge to community services.
- The service also completed a maternity dashboard to monitor key maternity indicators. We reviewed the data provided as part of our inspection. The trust's data and the maternity dashboard showed that the rate for normal delivery in the maternity service was worse than the national rate.

Safety thermometer

- We were able to review the local safety thermometer and found that the centre was within the expected range for all the indicators.

Cleanliness, infection control and hygiene

- The unit was clean and tidy and each room was stocked with appropriate personal protective equipment.
- Staff we spoke with confirmed that they had access to appropriate equipment and were able to talk through the principles of good hand hygiene and infection control measures within the centre.
- MRSA and Clostridium Difficile rates for the service were within an acceptable range.

Environment and equipment

- The centre was well maintained and fit for purpose. Staff told us that clinical waste was collected in a timely manner and they had no problems with their host location in regard to maintenance and access to support services. However, we found there was no service level agreement with the host trust to identify expectations about servicing and access to emergency continuity plans. This may have an impact on how emergency repairs or safe removal of waste are provided.

Maternity and family planning

- Appropriate equipment needed in case of a cardiac arrest and resuscitation of a new-born was available and stored on suitable trolleys that were able to contain the equipment safely if it was moved.
- There was evidence of adequate checking and recording of safe and serviced equipment. We found that the emergency equipment daily checklist was completed and up to date.

Medicines

- Staff records confirmed that midwives had received appropriate training in line with professional standards for the management of medicines. Staff we spoke with were knowledgeable about the drugs they used.
- Medicines were stored correctly, in locked cupboards or fridges where necessary. Fridge temperatures were regularly checked and recorded.
- Patient records showed clear documentation of medication and standardised medication charts were used across the service.

Pain Relief

- Entonox and intramuscular pain relief was available. There was also an excellent birthing pool to support women in labour.

Records

- During our inspection we reviewed a set of patient records. The record was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. The records were in paper format.
- We saw that the 'Child health record' (red book) was issued to mothers and advice was available on how to keep it as the main record of a child's health, growth and development.
- Midwives completed regular documentation audits and fed back the results through statutory supervision and professional development days.
- An external assurance visit for safeguarding had recently been carried out by the designated leads for children's safeguarding on behalf of NHS Cumbria Clinical Commissioning Group. It reported that although safeguarding information, such as risk assessments and vulnerability assessments, were included in patients' notes, they were not easily accessible. The service was implementing plans to ensure that summaries were available and located clearly within the records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place regarding the Mental Capacity Act 2005.
- Patients told us they had been asked for their consent before any procedures had taken place and they had received a full explanation. Patient records confirmed this.

Safeguarding

- Women and their babies were protected from abuse as staff were trained to deal with suspicion and allegations of abuse. Staff were aware of the signs of abuse and the appropriate actions and systems for reporting such concerns. A member of staff was able to describe her role as part of a coordinated approach to safeguarding a mother and her baby.
- The use of lead midwives for safeguarding had a positive impact on the staff and they felt well supported to manage any safeguarding concerns.
- NHS Cumbria Clinical Commissioning Group noted that safeguarding checks such as risk assessments and vulnerability assessments were in place and completed.
- Pregnant women were assessed in the community as part of their antenatal care and information about patients who were at risk was shared with appropriate staff.

Mandatory training

- Staff told us that they had been encouraged to complete their mandatory training prior to our inspection. They were aware that the service had achieved 92% completion rate for mandatory training, which included safeguarding and resuscitation training. Some staff told us they would have preferred less e-learning and more practical sessions as part of the mandatory training.
- The service had developed a robust training needs analysis to ensure that maternity services provided training in accordance with the national recommendations for all professionals working in maternity services. Staff confirmed that they had access to professional development days and regular PROMPT (Practical Obstetric Multi professional training) sessions were held that included all members of the maternity service.

Management deteriorating patients

- The service had processes in place to ensure that it recognised severely ill women during the pregnancy,

Maternity and family planning

delivery and the postnatal period. The service had introduced a modified early obstetric warning scoring system (MEOWS) to help improve the detection of women whose condition was deteriorating. There were clear directions for escalation printed on the reverse of the observation charts. Staff were aware of the actions to follow in such cases.

- The birthing centre had clear processes in place to safely transfer patients to the maternity unit at the Cumberland Infirmary in Carlisle.

Medical staffing

- Arrangements were in place to ensure a sufficient number of staff to provide safe care. The trust provided information that outlined how staffing levels were calculated. The service had the standard ratio of one midwife to 28 patient hospital births. Figures showed that 100% of women had one-to-one care in established labour, and staff confirmed this.
- We noted that the staff sickness rate was 4.8% against an England average of 4.3%. Some staff told us that the sickness levels had been higher than usual during the recent staffing review, but felt things were now more settled.
- We saw no evidence of acuity for identifying the number of staff required at the birthing centre. We were told that the service had trialled an acuity tool to assess the dependency criteria for maternity patients and had plans to introduce a formal acuity tool such as Birth Rate Plus, a recognised tool developed for maternity services to assess the staffing levels needed. However, the service did not currently utilise a formal acuity tool to assist in the calculation of appropriate staffing levels.
- Patients' follow-up care after delivery was provided in the community and they had access to band 3 support workers for both baby feeding and social support.

Medical staffing

- There was no medical staffing input at the birthing centre, as this was a midwife-led service. However, medical support was available through the Cumberland Infirmary if required.

Are maternity and family planning services effective?

Good



Care at the centre followed evidence-based guidance issued by professional and expert bodies. Records showed that the department had developed relevant clinical care pathways to ensure that patients received care appropriate to their needs. All deliveries at the centre were live births and the centre had a low readmission rate. Staff were competent and adopted a multidisciplinary approach seven days a week to provide effective care to women giving birth at the centre.

However, the centre was not being used to its full capacity. The data we saw showed that 60 women were booked for birth at Penrith, but following a risk assessment at 36 weeks only 23 were delivered there. Seven women required a transfer to the Cumberland Infirmary at Carlisle during labour and seven were unable to deliver at the centre due to a shortage of staff.

Evidence-based care and treatment

- Departmental policies and procedures were easily accessible electronically and staff were able to show us how they accessed policies.
- The trust's maternity governance committee reviewed relevant national guidance published each quarter to ensure that they were assessing themselves in line with appropriate current national standards. Staff we spoke with were clear what guidance was applicable to the service.
- The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs.
- There was a variety of information available to inform mothers. This was based on research and NICE guidance such as "pain relief in child birth."
- We saw audits for care of women in labour, perineal trauma, hand hygiene and clinical records.

Patient outcomes

- The service completed a maternity dashboard to monitor key maternity indicators. We reviewed the data

Maternity and family planning

provided as part of our inspection. The trust's data and the maternity dashboard showed that the maternity service had worse than national rates for normal delivery.

- Staff confirmed that they regularly carried out relevant audits and were able to give us feedback on the results of a recent infection control audit.
- We were shown a policy on breast feeding and we were told that the maternity service had recently appointed an Infant feeding coordinator.
- The service had better than expected readmission rates.

Competent staff

- The service had clear systems in place for supervision and appraisal. When we spoke with staff, some felt that they would like more time to discuss cases and junior staff told us that they would welcome more support from senior clinical staff.
- There were sufficient numbers of supervisors of midwives (SOM) within the birthing centre. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure the mothers and babies receive good quality, safe care. As supervisors, they provide support, advice and guidance to individual midwives on practice issues, while ensuring they practise within the midwives rules and standards set by the Nursing and Midwifery Council (NMC).
- All midwives (100%) had an annual review by their allocated supervisor.
- The service had recently implemented a review of midwifery staffing and had introduced several specialist midwife roles to lead specific areas of practice such as safeguarding, governance and obesity.
- Staff told us that they had received training in maternal mental health and they had access to appropriate clinical support for acute peri maternal health issues if needed. We saw that the service had clear policies and procedures for the management of the acute mental health needs of patients.

Multidisciplinary working

- We saw evidence of clear multi-disciplinary working across all professional groups. One person told us that "They worked well as a team and supported each other."
- Maternity staff were regularly asked to attend multi-agency meetings and contribute to pre-birth plans.

- There was good evidence of multi-agency liaison and communication for some high risk women to ensure they gave birth in an appropriate setting. The service had close access to physiotherapy services located adjacent to the birthing centre.
- Staff told us that they met with the health visitors regularly to share good practice and encourage information sharing about vulnerable patients.
- Good communication was evident between primary care and community health services.
- The community maternity team told us that they had close working relationships with the maternity unit in the Cumberland Infirmary in Carlisle and the communication processes were clear and effective. Staff were aware of the issues at Carlisle and were aware of the current lack of access to its birthing pool.
- The midwives were aware of their responsibilities to communicate with GPs during antenatal care/discharge and we saw examples of clear communication between GPs and midwives.

Seven-day services

- Services were available seven days a week

Are maternity and family planning services caring?

Good



Maternity services at the centre were delivered by committed and compassionate staff who treated patients with dignity and respect. All the people we spoke with were positive about the care they had received. Arrangements were in place to provide emotional support to patients and their families in a sensitive manner.

Compassionate care

- All the people we spoke with were positive about the care they had received. We had a large number of positive responses to our comment cards during the inspection. Comments included "I felt in capable hands", "Staff are friendly, welcoming and polite" and "All my concerns and questions were addressed by the staff."
- Patients were encouraged to give feedback on the service and systems were in place to gain patients' views by using the "Two minutes of your time" questionnaire

Maternity and family planning

to gain feedback. We saw examples of feedback that overall, were positive about the service with positive comments about staff attitude and the caring approach to patients.

- Results of the NHS Friends and Family test from 2013-14 showed that the service was comparable to the England average.
- The results for the service in CQC's 2013 survey of women's experiences of maternity services were in line with other trusts nationally for both care and information and explanations given by clinical staff.
- We spoke with one mother who had recently used the service and her comments included, "The staff were absolutely outstanding, so personal and excellent care."

Patient understanding and involvement

- Staff planned and delivered care in a way that took the patient's wishes into account. Women told us their consent had been obtained and everything had been explained clearly during the birth.
- Women told us that they had been involved in their care and felt very involved in decision-making.
- The use of hand-held records encouraged mothers to be aware of their birth plans and provided further information on any specific tests or investigations that may be required throughout a pregnancy.

Emotional support

- The service had a bereavement midwife to support women and their partners. We saw examples of further follow-up in the community if required to support women following bereavement.
- Staff we spoke with were very aware of the need to provide emotional support for mothers, and carried out assessments for anxiety and depression.
- If, at any time, mums wanted to talk through what happened, the service had an "Afterthoughts" postnatal listening service.
- Breast feeding support was available across the service. There was also support for breast feeding by healthcare staff working at the birthing centre.

Are maternity and family planning services responsive?

Good



The centre was responsive to the needs of women. For example, there were systems in place to meet people's religious and cultural needs and systems to manage patients who developed complications.

The service governance lead developed and implemented a maternity service integrated governance action plan to capture all the learning from audits and incidents. This had increased awareness of risk, and feedback on lessons learned had improved. Examples included improvements to communication and how patients were discharged to community services.

However, the lack of an agreed service specification made it difficult to assess whether the service was delivered according to the needs of the local population. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this group of patients. This lack of a clear service level agreement between the service and its host location (Penrith Community Hospital) could potentially affect the ability of the service to implement improvements and developments to respond to local need.

Service planning and delivery to meet the needs of local people

- The service had introduced relaxation classes at the birthing centre in response to comments from mothers. The classes aimed to improve education during pregnancy and help mothers prepare for birth.
- The service had systems in place to manage patients who developed complications.
- The Maternity Services liaison Committee had not met for two years. We were told that a meeting to re-establish the committee was planned for the week of our inspection to seek the views of women using the service. This was being led by the consultant midwife. We did not see any evidence that this committee was going to address the issues and plans for the birthing centre at Penrith.
- The lack of an agreed service specification made it difficult to assess whether the service was delivered

Maternity and family planning

according to the needs of the local population. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this group of patients.

Access and flow

- Policies were in place to escalate staffing issues on the unit. Staff were aware of how to access extra staff support if required.
- We did not see evidence of figures reporting on the number of women in labour being seen by a midwife within 30 minutes, which was supported by people we spoke with.
- Staff told us that they saw women regularly as required throughout their pregnancy, but evidence of figures to show the percentage of women accessing antenatal care at 10 weeks and 20 weeks was not available.
- Penrith Birthing Centre did not have a formal inpatient bed other than the birthing room. Specific occupancy figures were not available. Records showed that 60 women had booked into the centre for 2013, but only 23 gave birth in the unit.
- We noted that staff had reported several incidents when the birthing centre had been closed due to a shortage of staff. The staff told us that following the trust's review of maternity services, they did have access to more staff if required.

Meeting people's individual needs

- Information about how to contact the service was available in leaflets available on the maternity ward.
- The service had systems in place to meet people's religious and cultural needs.
- Leaflets were available for mothers to help them decide where to have their baby. The leaflet outlined the choices available for women, including the difference between midwifery-led care, consultant-led care and the options for home births or birth at the Penrith birthing centre. Other leaflets were also available such as "pain relief in labour". This helped women and their partners to make informed choices and decisions.
- The needs of women were assessed and birth plans were developed to meet those needs. Staff told us and records showed that each patient had a comprehensive assessment using nationally recognised pregnancy record documentation. This included a full medical

history, and personal preference plans for pregnancy, birth and parenthood. This took into account the individual mother's wishes such as preferences for birth and any specific wishes regarding breast feeding.

- Staff explained how they could access interpreters when required. A translation service was available but we saw no signs or leaflets about translation services.
- There was no evidence to show that information was available throughout the service in different languages or formats such as Braille or audio versions for visually or hearing impaired women.

Learning from complaints and concerns

- We found that although some complaint leaflets were available, information for both the role and contact details for the Care Quality Commission was out of date and inaccurate, and did not clearly point people to the Public Health Service Ombudsman.
- We saw information to tell people about the Patient Advice and Liaison Service (PALS), who could support people if they had concerns.

Are maternity and family planning services well-led?

Good



There was a positive culture among the midwives at the birthing centre. Locally, the midwifery staff felt positive about their clinical leadership. But they felt that the roles were not yet fully embedded and did not fully understand the roles of the clinical leads and the business manager.

Monitoring outcomes using the maternity dashboard was welcomed by staff, but our inspection team was told that it had only recently been introduced. This meant the data could not yet be compared with the previous year's activity. We noted the service did not have a local risk register although they contributed to the service risk register.

Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Maternity and family planning

There was no evidence of a clear vision for the service especially in light of the low utilisation of the centre. Staff expressed concerns about future sustainability of services at the location.

Vision and strategy for this service

- Staff told us that they had attended awareness sessions on the trust's vision. Staff were not clear what the trust's vision was for the location and had anxieties about the provision of care. Although staff felt part of the midwifery service, some did not feel fully engaged with the wider trust vision.
- This was compounded by the lack of an agreed service specification. There was a draft service specification but no clearly documented overview of the maternity service provision and no articulated vision for future service delivery.
- Staff told us that they felt things have improved since the maternity review, but they were still embedding the changes.
- There was low utilisation of the birthing centre. We saw no evidence of plans to increase the activity at the birthing centre to improve the effectiveness of care and treatment.

Governance, risk management and quality measurement

- There was no local risk register for the centre although they contributed to the service risk register.
- The centre was reviewing all transfers of women to the Cumberland Infirmary to assure themselves that the women gave birth in an appropriate setting.
- Monthly departmental meetings were held and well attended.
- There was a set agenda for these meetings with certain standing items including the review of incidents and monitoring of the maternity dashboard.
- The maternity dashboard was welcomed by staff but the inspection team was told that it had only recently been introduced so the data could not yet be compared with previous year's activity.
- We saw evidence that participation in national audits had improved and the staff we spoke with told us that they welcomed the introduction of the lead midwife for risk and governance.
- One individual was responsible for the manual collation of data and was monitoring service activity and delivery. The limited electronic systems had an impact on the centre's ability to monitor its own data.

- Staff reported that the new role of a governance lead for the service had resulted in an increased awareness in risk and that feedback on lessons learned had improved.

Leadership of service

- The midwifery staff felt positive about their clinical leadership, but felt that the roles were not yet embedded. They did not fully understand the roles of the clinical leads, and the role of the business manager.
- Staff welcomed the post of the midwife consultant as a leadership role. This consultant post had a remit for Public Health-Obesity, but none of the leadership roles had a clear remit to promote 'normality' in childbirth as supported by the Royal College of Midwives Campaign for Normal Birth and the National Childbirth Trust Birth Policy. Our inspection team felt that the midwife consultant role was not clearly defined and the capacity to lead on public health and 'normality' was limited due to the significant management component of the role in managing the specialist midwives. The staff at Penrith did not feel that the post had impacted upon their service in Penrith but they said they would welcome more visibility and access to the consultant.

Culture within the service

- The inspection team found a positive culture among the midwives working in the centre. They acknowledge the recent challenges within the service, but were positive about the changes.
- Staff had concerns about future sustainability of services at the location.

Public and staff engagement

- Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Innovation, improvement and sustainability

- We found that the service had made significant improvements in regards to developing a culture of improvement.
- Staff had been engaged in developing new roles and now felt they were getting feedback on complaints and starting to learn from incidents.
- Our inspection team noted that the lack of information systems was having an impact on the service's ability to adequately record information about the clinical care of

Maternity and family planning

women and the complexity of their cases. All the data we were shown had been collated manually. We were told that the service had recently received approval to introduce the IT data systems needed to help develop innovation and improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **SHOULD** take to improve

- Ensure the quality of information to improve the support for women who wish to complain. We found that although some complaint leaflets were available, information on both the role and contact details of the Care Quality Commission was out of date and inaccurate, and the leaflets did not clearly direct people to the Public Health Service Ombudsman.
- Ensure there is a service level agreement with the host trust to identify expectations about servicing and access to emergency continuity plans.
- Develop a local risk register for the centre to underpin the service risk register and ensure local risks are recorded, mitigated and escalated appropriately.

Although we did note that the service was reviewing all transfers to the Cumberland Infirmary to gain assurance that women give birth in an appropriate setting.

- Clarify the governance structure, as the Maternity Services Liaison Committee had not met for two years.
- Clarify a leadership role with a clear remit to promote 'normality' in child birth as supported by the Royal College of Midwives Campaign for Normal Birth and the National Childbirth Trust Birth Policy.
- Consider using information technology to improve the effectiveness of data flows. We were informed that the centre had recently received approval to introduce the IT data systems needed to help develop innovation and improvements.