Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Penrice Birthing Centre

Quality Report

St Austell Community Hospital
Porthpean Road
St Austell
Cornwall
PL26 6AD
Tel: 01726 873000
Website: www.rcht.nhs.uk

Date of inspection visit: 6 July 2017
Date of publication: 05/10/2017

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

Ratings

Overall rating for this hospital	Requires improvement
Maternity and gynaecology	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The Trust serves a population of around 532,273 people, a figure which can be doubled by holiday makers during the busiest times of the year.

The trust maternity services provide antenatal, intrapartum and postnatal care in the Royal Cornwall Hospital and within local community settings divided into three geographically based community midwife teams including Penrice Birthing Centre which is located in the grounds St Austell Community Hospital.

The maternity services are part of the women, children and sexual health division of the trust. A community midwife team leader manages Penrice Birthing Centre on a day to day basis and reports to the community midwifery matron at Royal Cornwall Hospital.

This is an announced focussed inspection of Royal Cornwall Hospitals NHS Trust to assess if improvements have been made following the previous unannounced focussed inspection carried out in January 2017. We inspected the centre as part of this inspection on 6 July 2017.

We rated Penrice Birthing Centre as requires improvement overall.

Our key findings were as follows:

There were areas of poor practice where the trust needs to make improvements:

- Staff at the birth centre did not audit their activity to provide assurance of delivery of care in line with trust guidelines and its effectiveness.
- The transfer rate to hospital from the birth centre was higher than the national average and the service had not analysed this fully.
- A number of risks such as ambulance delays and whether all community midwives had the skills to deal with some emergencies while awaiting an ambulance were not on the risk register at the time of the inspection, although the trust added these in August 2017 after we raised concerns. There was no local risk register for the Penrice birth centre or the regional community midwifery service.
- There was no community midwifery dashboard to give an oversight of community performance and no documentation audits to assure managers that all midwives were following guidelines.
- There had not been a full risk assessment of lone working arrangements involving community midwives themselves, for the new model of care when the first on call midwife attends the birth centre.
- There was no audit plan for community midwifery to provide assurance of effective delivery of care in line with trust guidelines.
- Conflicting advice in guidelines about incident reporting was confusing: for example the trigger list for incident reporting in the Maternity Risk Management strategy contained different advice to the Home birth guideline.
- Not all midwives were up to date with their mandatory training and compliance was set at a lower level than 95% target for training completion set by the trust.
- There was no documented vision and strategy for the birth centre and community midwifery.
- Midwives did not have clear written guidance about MEOWS and obstetric emergencies in the community. There was no written guidance on baby weight loss.
- There was no benchmarking of processes against comparable trusts in rural areas.
- Community midwives felt remote from strategic decision-making.

Importantly, the trust must:

Summary of findings

- Ensure there is a review and full risk assessment of lone working arrangements under the new model of care when the first on call midwife attends the birth centre.
- Identify, analyse and manage all risks of harm to women in maternity services, ensuring local risk registers are maintained in all discrete units and feed into the divisional and corporate risk register.
- Ensure all midwives update their training to a level where they all have the skills needed for their roles, and set targets for completion of training in line with trust targets of 95%.
- Ensure better quality data about processes and outcomes within the maternity services is available for analysis and to support improvement.
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures are effective. Ensure audits are aligned to incidents and identified risks.
- Ensure the maternity dashboard includes sufficient information to provide a comprehensive overview of maternity performance. Proactively benchmark processes and outcomes in the maternity service against comparable trusts in rural areas.

In addition the trust should:

- Consider developing a community specific dashboard display to give a comprehensive overview of community maternity performance. .
- Clarify whether midwives should record all intrapartum transfers from the community as incidents.
- Review the back-fill arrangements when midwives working on call have to work at night to ensure they are fit to work their shift next day.
- Consider how the vision and strategy for the birth centre and community midwifery are documented and communicated.
- Develop clear written guidance for midwives about maternal observations, managing community obstetric and neonatal emergencies, baby weight loss and feeding concerns.
- Develop policies and guidelines with more involvement of a range of relevant staff, particularly those who will need to implement the policy or are affected by it.

However, there were areas of good practice including:

- The birth centre offered women a compromise between home and hospital in a clean, relaxed, non-clinical environment.
- The birth centre offered facilities that were not currently available in the hospital: spacious accommodation with labour aids such as birth balls, padded mats and birth stools and a pool for pain relief or water birth.
- Community midwives offered care before, during and after birth which gave reasonable continuity of care to women within reasonable distance of their homes
- Women wanting to give birth at the centre were screened appropriately to ensure they were low risk.
- Care was delivered with kindness and compassion. Patients and their partners were involved and emotional support was good.
- Incidents were reported and there was evidence of learning as a result.
- The trust achieved a much higher community birth rate than the national average: 11.4% compared to 2% nationally.

We also saw the following outstanding practice:

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Requires improvement 	We rated this service as requires improvement because:

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- The transfer rate to hospital from the birth centre was higher than the national average and the service had not analysed this fully.
- A number of risks such as ambulance delays and whether all community midwives had the skills to deal with some emergencies while awaiting an ambulance were not on the risk register at the time of the inspection, although the trust added these in August 2017 after we raised concerns. There was no local risk register for the Penrice birth centre or the regional community midwifery service.
- There was no community midwifery dashboard to give an oversight of community performance and no documentation audits to assure managers that all midwives were following guidelines.
- There had not been a full risk assessment of lone working arrangements involving community midwives themselves, for the new model of care when the first on call midwife attends the birth centre.
- There was no audit plan for community midwifery to provide assurance of effective delivery of care in line with trust guidelines.
- Conflicting advice in guidelines about incident reporting was confusing: for example the trigger list for incident reporting in the Maternity Risk Management strategy contained different advice to the Home birth guideline.
- Not all midwives were up to date with their mandatory training and compliance was set at a lower level than 95% target for training completion set by the trust.
- There was no documented vision and strategy for the birth centre and community midwifery.

Summary of findings

- Midwives did not have clear written guidance about MEOWS and obstetric emergencies in the community. There was no written guidance on baby weight loss.
- There was no benchmarking of processes against comparable trusts in rural areas.
- Community midwives felt remote from strategic decision-making.

However

- The birth centre offered women a compromise between home and hospital in a clean, relaxed, non-clinical environment.
- The birth centre offered facilities that were not currently available in the hospital: spacious accommodation with labour aids such as birth balls, padded mats and birth stools and a pool for pain relief or water birth.
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Penrice Birthing Centre

Detailed findings

Services we looked at
Maternity and gynaecology;

Detailed findings

Contents

Background to Penrice Birthing Centre

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The trust serves a population of around 532,273 people, a figure that can be doubled by holiday makers during the busiest times of year.

The trust maternity services provide antenatal, intrapartum and postnatal care in the Royal Cornwall Hospital and within local community settings divided into three geographically based community midwife teams: West Cornwall, Central Cornwall and North Cornwall/ Penrice. The maternity services are part of the women, children and sexual health division of the trust. A community midwife team leader manages Penrice birth centre on a day to day basis and reports to the community midwifery matron at Royal Cornwall Hospital.

Penrice birth centre, which opened in 1999, is a purpose-built, midwife-led unit, located within the grounds of St Austell Hospital which is owned and managed by another organisation. The building is leased from them. The facilities include two birth rooms, one with a birthing pool and one with a large bath, two postnatal rooms (no longer in use), a kitchen and a garden area. There is also a parent education room and antenatal consulting room. Community midwives based at the centre carry out antenatal checks, look after women in labour and during birth (both for births at the birth centre and at home) and carry out postnatal checks. The birth centre is able to receive and provide care for women 24 hours a day, however it is staffed overnight. Midwives provide on call cover after 8pm.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director of an Independent Healthcare Management Consultancy

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

The Penrice birthing centre team included a CQC inspector, an inspection manager and two senior midwives.

Detailed findings

How we carried out this inspection

Prior to the inspection we reviewed a range of information we hold about the hospital and the trust in general, including information from Healthwatch Cornwall and Kernow Commissioning Care Group.

We inspected the maternity services at the hospital as part of our announced inspection between 4 and 7 July 2017 and visited Penrice Birth Centre as part of that inspection on 6 July 2017. Before, during, and after our inspection we reviewed the trust's performance information.

CQC last inspected the centre in November 2013 when it met all standards that were inspected at that time.

We observed how people were being cared for and reviewed patients' records of their care and treatment.

Facts and data about Penrice Birthing Centre

In 2016/2017 there were 218 births at the birth centre, which amounted to 5% of births in the trust. The number of births had fallen from 2015/6 when there were 270 births. About half the women who originally booked for delivery at Penrice did not give birth there, generally because of problems during pregnancy which indicated a referral into the consultant led unit.

Our ratings for this hospital

Our ratings for this hospital are:

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

Maternity and gynaecology

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Royal Cornwall Hospitals NHS Trust (RCHT) maternity services provide antenatal, intrapartum and postnatal care in the Royal Cornwall Hospital and within local community settings divided into three geographically based community midwife teams: West Cornwall, Central Cornwall and North Cornwall/Penrice. The maternity services are part of the women, children and sexual health division of the trust. A community midwife team leader manages Penrice birth centre on a day to day basis and reports to the community midwifery matron at Royal Cornwall Hospital.

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Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

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- The transfer rate to hospital from the birth centre was higher than the national average and the service had not analysed this fully.
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- There was no benchmarking of processes against comparable trusts in rural areas.
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However

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- Incidents were reported and there was evidence of learning as a result.
- The trust achieved a much higher community birth rate than the national average: 11.4% compared to 2% nationally.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Conflicting guidance for community midwives on what to report as incidents as confusing. For example the trigger list for incident reporting in the Maternity Risk Management strategy contained different advice to the Home birth guideline.
- Midwives did not categorise incidents consistently making it hard to identify and monitor trends.
- Midwives had concerns about their own safety working alone and opening the Penrice birth centre at night. There was also a risk to mothers if the lone midwife was distracted by an event not related to the birth.
- The decision to divert triage calls from the hospital to the birth centre between 5pm and 8pm did not have a clear contingency arrangement if the midwives at Penrice were with labouring women.
- There was no regular audit of women's notes to assure managers that all midwives were following guidelines. The clinical review meeting did not review antenatal or postnatal notes.
- We could not be assured that community midwives had up to date skills. They did not have training to cannulate women and did not have the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.

However:

- Staff were aware of their responsibilities for safeguarding. They understood the thresholds for making safeguarding referrals and those made were appropriate.
- Women were screened appropriately to assess their level of risk in pregnancy and birth.
- Midwives considered there were enough staff at Penrice and this appeared to us to be the case in relation to the level of activity including the number of births at the birth centre.
- We saw that learning from incidents was incorporated in training as well as through written communications such as the risk newsletter.

Incidents

- There was an electronic incident reporting system, which community staff could access at Penrice birth centre. Staff we spoke with understood their responsibilities to report safety incidents in line with a trust 'trigger' list showing the type of incidents to report. Between June 2016 and May 2017, 48 incidents were reported by the Penrice and North Cornwall team, some relating to antenatal and postnatal appointments, 14 in relation to births at Penrice and others relating to transfers to hospital. Staff told us they discussed incidents with their team leader at monthly meetings.
- Staff did not routinely report transfers into the delivery suite from the community as incidents because the trigger list for incident reporting in the Maternity Risk Management strategy said only emergency transfers need be reported. However, there was conflicting advice within the trust's maternity guidelines as the Home birth guideline said all transfers should be reported. Only one transfer from Penrice was shown on the incident report but the trust confirmed that 94 women were transferred during 2016/7. This meant the service was unable to analyse transfers fully and to benchmark performance against other trusts.
- Some babies were born each year before the midwife arrived. This is known as Born before attendance (BBA). There were three babies BBA reported for the Penrice/ North Cornwall area in 2016/7. Staff had reported these as incidents and classified them as born before arrival. However, these did not all appear on the maternity dashboard which showed only one baby born before arrival in 2016/7.
- The risk midwife based in the hospital reviewed all incidents and selected higher risk cases or incidents where there was harm to the mother such as a third degree tear, or an unwell baby for discussion at the weekly clinical incident review meeting. However, this did not include all incidents which meant near misses were not discussed and trends were not monitored. The community matron attended these meetings. Key learning points from these meetings were summarised in the monthly Maternity Risk Management newsletter which all midwives received. The newsletter also contained a high level overview of all incidents each month showing the main types of incident, example medication errors times when staffing fell below the minimum or midwives not following protocols such as

not using the SBAR chart. There was no breakdown between incidents in the community and those in the hospital. Midwives told us they discussed these incidents with their team leader. However, there was no forum for case review of community births or to look at trends such as reasons for transfer from home or birth centre to hospital.

- Community midwives we spoke with were able to give examples of feedback and learning from incidents which had changed practice. For example the addition of women who missed antenatal appointments to the trigger list for possible safeguarding concerns.
- There were no Never events at Penrice Birth Centre. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no serious incidents requiring investigation at Penrice Birth Centre, but there was one reported incident of significant blood loss of over 1000 ml after delivery which required the woman to be transferred to the Royal Cornwall Hospital for management. Where serious incidents in the trust had required investigation the risk midwife emailed the reports to midwives and put a summary in the newsletter so midwives could learn from what had occurred in discussion with their team leader.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Midwives we spoke with understood the duty of candour and the need to apologise to mothers and families when things went wrong. They told us there had not been any incidents at Penrice birth centre or in the north region which had required a written duty of candour response.
- Not all maternity staff had completed the trust's duty of candour training. 86% of nursing, midwifery and clerical staff had completed the training which was considerably below the trust target of 95%. Duty of candour training data was not recorded on the trust wide training matrix and there was no breakdown specifically for community midwives.

Safety thermometer

- The maternity safety thermometer is a measurement tool for improvement that focuses on blood loss over 500 ml, tears to the area between the vagina and rectum from giving birth, maternal infection, the psychological well-being of the mother and the baby's health scores in the first 10 minutes after birth. Monthly data returns were made to the NHS maternity safety thermometer, however these were trust wide. There was no specific data available for Penrice. This meant the safety data for low risk women could not be differentiated from those of higher risk women in the acute trust.
- Safety thermometer data was not displayed so women would not have information about the safety performance of Penrice birth centre.

Cleanliness, infection control and hygiene

- We visited all areas of the birth centre and found it visibly clean and tidy, with adequate antibacterial hand washing and hand gel facilities throughout.
- Domestic cleaning was carried out by staff working for the organisation from which the trust leased the birth centre. The domestic staff we spoke with reported ready access to cleaning materials and equipment. There were set schedules for cleaning. In the event of a birth out of hours, midwives were responsible for cleaning all areas of the birthing room. Cleaning materials were stored in a locked cupboard that midwives had ready access to.
- Staff followed the trust's Infection Prevention and Control policy and Hand Hygiene policy, as well as the Decontamination policy to ensure that all equipment was thoroughly cleaned, disinfected and sterilised as appropriate to reduce the risk of infection. The decontamination cleaning included birthing pools, delivery beds and cots. Staff were observed adhering to the trust's 'bare below the elbow' policy
- We observed staff washing their hands or using antibacterial hand gel which was also available for visitors. Staff also had access to personal protective equipment, such as gloves and aprons.

- The disposable privacy curtains around the pool area in the birthing rooms were clean and the date indicated staff had recently changed the curtains in line with the policy.
- Waste management and water supply checks were carried out and monitored by the host trust under the leasing agreement.

Environment and equipment

- Both birthing rooms contained a range of wipe-clean equipment for women to use to mobilise during labour such as birthing balls, floor mats, bean bags and birthing seats.
- Access to the birth centre was secure and controlled by intercom. The birth centre clerk could see the visitor on a screen then released the door remotely on confirmation that the visitor was expected. There was CCTV on all four doors to the centre between 8 am and 8pm. When the on-call midwife opened the birth centre at night, the screens would not be monitored.
- The centre had an ambulance bay with wide doors for use in the event a woman needed a hospital transfer.
- The birth centre had an emergency resuscitation trolley for adults, equipment for anaphylactic shock and an adult ambu bag (face mask). The trolley had a list of contents attached to it and all equipment was in working order and in date. The trolley also held forms to record cannula insertion and guidelines on the management of a massive obstetric haemorrhage, umbilical cord prolapse and management of shoulder dystocia.We saw that staff checked these weekly and signed to confirm the check.
- The unit also had a resuscitaire and radiant warmer if needed for a baby. However, a number of disposable catheters in the drawer under the resuscitaire were out of date. We drew this to the attention of the midwife in charge who replaced them immediately.
- There was no defibrillator in the birth centre. The centre's pathway for emergency care was to request an ambulance for peri-cardiac arrest. 91% of midwives at Penrice birth centre were up to date with adult life support training.
- The storage room for clinical and other equipment had sufficient stocks, and was tidy and well organised with evidence of stock rotation. We found no out of date items. Staff ordered replacement consumables and equipment from the Royal Cornwall Hospital. This ensured there was sufficient stock for use as required.
- The Royal Cornwall Hospital managed maintenance of equipment centrally and we discussed equipment arrangements with a member of the team. All items we looked at the birth centre had been safety tested and items such as scales had been calibrated within six months. There were no incidents recorded in the incident report for 2016/7 relating to equipment failure in the community, and staff we spoke with a Penrice confirmed that this was their experience.
- Women having a home birth were given list of equipment they would need to supply themselves such as clothing for mother and baby, towels and plastic covering for bed or floor, as well as a packed overnight bag in case of transfer to hospital. The midwife would discuss this with the mother at 36 weeks.
- All midwives had standard equipment in line with the current Community Midwife Equipment List. Antenatal and postnatal equipment included baby scales, stethoscope, thermometer, blood pressure meter and carbon monoxide monitor. The birth equipment included Entonox equipment and disposable mouthpiece, a placenta bag, catheter bag and perineal repair pack. We checked the contents of one bag. Midwives carried clinical waste bags as part of their equipment for disposal of waste.
- There was a schedule for checking and calibrating equipment, for example Entonox and scales were checked every six months. We saw stickers with the calibration date on the items we checked.
- Midwives were responsible for monitoring and restocking their own equipment which they stored in bags provided by the trust. Staff told us a new service wide equipment asset register was under development to monitor community midwives' equipment across Cornwall. This was not yet in place.
- There was an intrapartum 'grab bag' at Penrice Birth centre for a midwife to take in the event that a woman was transferred to the hospital by ambulance. The midwife using this ensured this was checked and restocked after use. The contents included a delivery pack, swabs, towels, a neonatal bag and mask and syringes and needles. There was also a weekly check on the contents.

Medicines

- Midwives and maternity support workers were aware of the trust's medicine management policies and followed them. The centre kept a small supply of medicines in a

locked cabinet in a locked treatment room. We checked all medicines in the cabinet and they well organised and in date. The newest stock was at stored at the back to ensure there was effective stock rotation. Additional stocks were ordered from the Royal Cornwall Hospital pharmacy and delivered weekly if needed. Orders were authorised by the team leader.

- There was a separate cupboard for storing a small number of controlled drugs such as pethidine. The logbook was correctly completed and drugs were clearly labelled. Midwives signed if they removed these from the cupboard. There was a controlled drugs order book used to request stocks, and medicines were delivered from pharmacy in a tamper proof bag. There was a standard receipting process when orders were received.
- Midwives only administered drugs covered by midwives' exemptions which allowed them to give timely medication, such as pain relief, to women without the need to involve a qualified prescriber.
- Community midwives gave whooping cough vaccines to pregnant women from 20 weeks up to 32 weeks to help protect babies from this disease as babies could not be vaccinated until they were two months old. Midwives administered these under Patient Group Directions (PGD). (PGDs are specific written instructions for administration of a named prescription medicine, including vaccines). Although staff were trained in administering vaccines they had not yet been trained in making the required returns to NHS England and commissioners. This had come to light in July 2017 and training was being planned. Not all midwives in the North Cornwall/Penrice were yet trained but the rota ensured there was always a trained midwife available until all midwives were trained.
- The drugs midwives carried appropriate drugs to home births.
- Cylinders of oxygen and Entonox (medical nitrous oxide and oxygen mixture) were securely stored inside the doors to the ambulance bay. The area was well away from ignition and heat sources in line with trust policy. The doors were locked and CCTV oversaw the entrance. Midwives did not currently carry oxygen to home births but we heard at the senior midwives meeting that had been suggested because of the delays in ambulance attendance. The suggestion had not yet been risk assessed.
- Midwives we spoke with told us they were aware of legal safety requirements in carrying nitrous oxide and oxygen mixture in their cars and were aware of the risks, the need for good ventilation and said they and carried fire extinguishers. There was no evidence that of informal checks or whether this was audited.
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Records

- During our inspection we saw staff managed records securely and no confidential patient information was left on desks in the office. Staff had training in information governance which covered confidential records management.
- Women carried their own hand held notes. Records were a combination of paper and electronic information. There was no regular audit of maternity records. Patient notes were currently only reviewed in specific cases where an investigation of an incident prompted review or an audit required access to a sample of patient records. Whilst senior managers were aware of the value of auditing patient notes to ensure quality and had a generic tool to use for this, this did not feature in the audit program.
- Midwives did not have remote access to the hospital maternity information system from locations such as GP surgeries. Laptop access was planned with the new system due in autumn 2017.
- Records were returned to the Royal Cornwall hospital for storage after women were discharged from midwifery care. There was a Standard Operating Procedure for merging of hand held records with the hospital record. This was an interim solution pending the introduction of a new electronic maternity information system in the autumn. The interim solution ensured that women's pregnancy history could be retrieved for a subsequent pregnancy.
- Midwives had not in the past always completed the child health record (Red book) to handover care to health visitors, which risked health visitors not being alerted to concerns. A process had been introduced in April 2017 for midwives to inform health visitors electronically of all pregnancies at 25-28 weeks with an 'exceptional reporting form', to alert them to post-natal issues at discharge.

Safeguarding

- The Chief Nurse was the named nurse for safeguarding in the trust. Since February 2017 the two safeguarding midwives had worked as part of an integrated hospital

adult safeguarding team, with the learning disabilities service and the mental health and well-being specialist nurse from another trust. They also worked alongside Cornwall social services. We noted that the February staffing review took account of time spent on safeguarding work in the staffing calculation for each region.

- The training matrix showed, and staff confirmed, that safeguarding training at level three was delivered in a classroom setting by the safeguarding team. Training data specific to Penrice midwives was not available, but trust wide, 88% of midwives were up to date with level 3 training. All the midwives we spoke to at Penrice had attended level 3 training in the past year.
- Midwives we spoke with were aware of their responsibility to report safeguarding concerns about vulnerable women, or families at risk during the antenatal, intra partum and postnatal period. Unless the concern was very urgent they would raise the concern first with the team leader for the unit, to avoid unnecessary contact with the multi-agency safeguarding team.
- Midwives assessed the vulnerability of women at the booking appointment and at subsequent appointments, including asking mothers about domestic violence at the 'woman only' 16 week check. We saw information about support services available. Young women under 18 did not give birth at the centre.
- No teenage pregnancy clinics were run in Cornwall because of the geographical spread of such cases. Young women saw midwives in their local area to minimise travel. In 2016/17 there were 10 births to young people under 16 and 49 births to those under 18 across Cornwall. Midwives had access to information leaflets appropriate to teenagers. Cornwall Council ran a young parents service.
- The new maternity information system, due to be available in October 2017 was being designed to flag up issues such as child sexual exploitation, female genital mutilation, honour-based violence, forced marriage, human trafficking and preventing radicalisation as well as children in need or where the unborn baby was subject to a child protection order. In the meantime, midwives referred to the hospital's database of safeguarding referrals and concerns to see if women or family members were subject to a child protection or children in need plan. This database had been set up following a 2015 CQC inspection of safeguarding and looked after children, which had made a number of recommendations to improve the safety of vulnerable women and families.
- The handover to health visiting in the postnatal period incorporated safeguarding concerns. Midwives had the opportunity to attend group safeguarding supervision in their regions. Midwives making a referral were offered 1:1 supervision, and midwives could also request 1:1 supervision in other circumstances.

Mandatory training

- A recently revised training strategy dated 2017, covered training for midwives and for the multidisciplinary team. The target for attendance at training was 85% which was below the trust wide training target of 95%. Not all training for midwives was incorporated in this guidance.
- Mandatory trust training included infection prevention, fire safety, manual handling and basic life support. An annual maternity update day covered antenatal screening, blood transfusion competency, smoking cessation, healthy weight, new born feeding, mentorship, diabetes and bereavement. This was delivered as a monthly rolling programme. Penrice specific training data was not available; however, figures up to May 2017 showed 79% of community midwives had attended training. This fell below the level set by the service of 85% compliance. Midwives were individually reminded of the need to attend an update day as soon as possible. New topics were added to training reinforce learning from incidents, for example a recent training day had included a half hour session on the importance of risk assessments for venous thromboembolism (VTE).
- Midwives were responsible for monitoring their own compliance with statutory and mandatory training which was partly on-line and partly face to face. A practice development midwife oversaw the training database and had an overview of compliance. However, the new community matron intended to take a stronger role in monitoring training compliance.
- The trust ran training in obstetric emergencies. This included response to maternal collapse, massive obstetric haemorrhage, sepsis, intrapartum foetal monitoring and neonatal resuscitation. The training was a mix of presentations and practical skills. 91% of midwives at Penrice birth centre had attended this training. The policy on community birth said that all

midwives in the community must ensure competence at managing obstetric emergencies and have attended trust mandatory training and obstetric emergency training within the last 12 months.

- Some 20 community midwives (Cornwall-wide) had specific training on emergencies in the community at the time of the inspection. The trust confirmed that midwives from Penrice were booked on courses in September and October. By 7 September 2017 the trust told us 70% of community midwives would have undertaken this training. We were not given training figures specifically for Penrice but among community midwives as a whole, 77% had attended an annual maternity update day, 90% of midwives were up to date with CTG training and 97% had attended the obstetric skills drills training.
- All midwives undertook new born life support training as part of the practical emergency training However, in July 2017 only 55% of midwives (service wide) identified as needing the four yearly Resuscitation UK training on newborn life support were up to date with this training. The service had made this training mandatory in 2017.
- Maternity support workers (MSW) had five days mandatory training on joining the trust, including manual handling, supporting breastfeeding, sepsis training, safeguarding and tissue viability. All MSW were up to date with training.

Assessing and responding to patient risk

- Midwives carried out a risk assessment of each woman at the first booking appointment. Service wide 91% of bookings were made by 12 weeks. No data was collected on bookings by 10 weeks, although the trust antenatal guideline recommended this and it was important for early screening.
- The initial risk assessment included whether pregnancy and labour were likely to be low or high risk and whether a home birth, midwife-led birth or hospital birth was likely to be appropriate. Risks considered included maternity history, multiple birth, previous caesarean section, weight, age, blood pressure and conditions such as diabetes or high body mass index and offered screening test results. These included blood tests for blood group and rhesus D status, as well as for genetic blood defects, hepatitis B virus, HIV or rubella susceptibility, urine tests (to check for protein in urine which might indicate kidney problems and to screen for bacterial infections without apparent symptoms) and an ultrasound scan to determine gestational age. The initial assumption was that women identified as low risk could have home or birth centre births, but low risk women could choose obstetrician led care.
- Women with multiple pregnancies were at higher risk of complications and would be referred to an obstetrician as well as having community midwife appointments. They would be advised to birth in the hospital.
- Midwives reviewed risk assessments at subsequent antenatal visits. Women could plan birth at Penrice Birth Centre when the progress of the pregnancy at 32 weeks indicated a low risk.
- Midwives referred women identified as being higher risk, for example because of diabetes or previous pregnancy complications to an appointment with an obstetrician. Most women, continued to have appointments with the community midwife when pregnancy care was shared. Women also had access to the foetal medicine unit at the hospital for ultrasound and other screening. Women with risk factors as identified in the booking risk assessment or later on in pregnancy were advised to deliver at Royal Cornwall Hospital.
- Midwives assessed women's mood during antenatal visits in line with NICE clinical guideline 192. They were able to signpost women to sources of help for anxiety and depression. A perinatal mental health team from another trust supported women affected moderate to severe mental health illness during pregnancy and after birth. The maternity service had links with the charity Addaction for women misusing alcohol and drugs.
- We reviewed the trust's criteria for birth centre and home births, which were strict and appropriate. These included age (18-40), body mass index (18 -35), a single baby and expectation of straightforward labour and delivery. If women wanted a home birth, a midwife undertook an environmental risk assessment of the home and proposed birth space, including lighting and equipment in the home. Women were advised of items they would need to supply. The assessment of the home included assessment of access for emergency services.
- A maternity triage system assessed women who thought their labour had started or who had other concerns such as reduced foetal movements or vaginal bleeding. During the day women called their community midwifery team for advice on the appropriate action. At night the triage midwife at the hospital would assess the risks.

- If a woman was in labour at home or in the birth centre, and the labour was slow or there were other indications that intervention might be needed for the safety of woman and baby, the midwife would consider transfer to the hospital delivery suite. The midwife discussed this with the woman and her partner, taking account of the time and distance to reach the hospital. A clear protocol for calling an ambulance and notifying the delivery suite was set out in the Maternal Transfer by Ambulance guideline. There was a standard form for completion on transfer. Staff had training in the SBARD tool (Situation, Background, Assessment, Recommendation and Decision) tool to report information to other professionals. We did not witness this communication tool being used in the community. However, we saw from other records that transfer forms were not always completed so there was not a clear audit trail showing the reasons for every transfer.
- The guidelines on home and community births required midwives to use Modified Early Obstetric Warning Scores (MEOWS) charts for monitor women and National Early Warning Score to monitor the newborn baby. However records were not audited to demonstrate compliance with this
- The trust used the electronic incident reports as the main source of information about maternity activity. There was no routine audit of women's notes to provide assurance that midwives were keeping good records and identifying and mitigating risks when there were no reportable incidents.
- Midwives in the community, by the nature of the jobs, worked alone some of the time. The trust had a lone working policy which took account of most recent guidance from the Royal College of Nursing (2016). However, midwives working under the new model of working at Penrice did not feel the service had fully assessed the risk of working in Penrice birth centre out of hours. The switchboard and triage midwife at night knew where on call community midwives were working. For opening the birth centre, the trust had followed the guidance that if a worker is working at another employer's workplace they should discuss the risks with the other employer. However, staff told us they did not feel the arrangement to notify night staff on the ward nearest the birth centre when they were opening the centre at night was adequate security.
- Midwives at the birth centre were trained in support for women who choose to labour in water. This training included the use of the hoist and the trust moving and lifting guidance in the event a woman needed an urgent assisted exit from the birthing pool. When women used the birthing pool in labour midwives checked maternal, water and room temperatures and recorded these hourly with the times of entering and leaving the birthing pool and reason for leaving. This was in line with trust guidance. Midwives were able to tell us the risk factors necessitating leaving the birthing pool such as maternal fever or the presence of meconium stained liquor. There was a hoist for use in an emergency and staff were trained how to use this.
- A few women who did not meet guidelines for birth at the birth centre or at home nonetheless wanted to give birth in the community. Midwives told us they had a duty to explain the risks to the woman, so the woman could make an informed decision. This was in line with the trusts 'Community Birth, Midwifery Led Pregnancy Care and Born before Attendance guideline' which described a process to follow when a woman rejected a midwife's advice. The midwife would report their concerns to the birth centre manager and seek guidance from the supervisor of midwives about planning care. The guideline had not been updated to reflect that there were no longer statutory supervisors of midwives, but staff said they would involve the community matron instead. Senior staff would advise on how to manage the case depending on the individual circumstances. The risks to the woman would be reviewed at each antenatal appointment.
- The maternity dashboard showed that many woman who initially booked to give birth at Penrice birth centre, did not ultimately do so. In 2016/7 of the 498 women booked for delivery at Penrice only 218 women gave birth there (43%). No analysis of the reasons had been undertaken.
- Midwives told us about the risk of delay in ambulance attendance at night due to the rural county. This was not on the maternity risk register at the time of the inspection but the trust added it in August 2017 after discussion with CQC.
- We had concerns that, not all community midwives were trained in cannulation which would limit their ability to provide first line support to mothers and babies while waiting for an ambulance. Following our concerns being raised, the trust conducted a risk assessment and told us of plans to train midwives in the skill through the use of an on line training resource. It

was not clear how midwives would obtain the practical skills to undertake this. Midwives were to be issued with boxes containing equipment to allow them to cannulate, however, they did not carry the necessary intravenous fluids to administer following their insertion. The risk assessment did not include means of mitigating the risk in the interim.

- Women going home after a birth at the centre took their maternity handheld notes which included the 24-hour telephone contact number for the on call midwife should the woman need any advice before the community midwife visited the following day. The hand held notes contained a section on post birth care, which gave women and their partners' information about common health problems in the postnatal period for both the woman and the baby, and how to recognise and respond to concerns about their baby's health.
- In June 2017 a decision had been made to divert triage calls from the Royal Cornwall Hospital's Day Assessment Unit to Penrice between 5pm and 8pm because of the pressure on the workload in the Day Assessment Unit at that time. The activity at Penrice had not been taken into account to ensure that staff at that unit had capacity to take those calls, for example, if a midwife was with a labouring woman. During the day, community midwives undertook triage for women in their own area.

Midwifery staffing

- Staffing in the community teams that covered the birth centre was based on a nationally recognised workforce planning tool .However, the last full plus assessment was in 2015 with a reassessment planned for autumn 2017. The head of midwifery reviewed staffing with community team leaders every six months though this discussion was not supported by the use of a recognised planning tool.
- At the staffing review in February 2017 the head of midwifery had adjusted staffing requirements in the community to take account of changes in community midwives' activities, and the need to control expenditure. The February review had increased the time for booking appointments to two hours, included time for baby checks for babies born in the community and reduced time for attendance at births from 12 hours to 10 hours for the first midwife, and to two hours (from three hours) for the second midwife.
- The Penrice community team was fully staffed at the time of our inspection, based on the trust's revised assessment of staffing needs in February 2017. There were 12 midwives at the centre. The staffing included supernumerary student midwives, a clerk and midwifery support workers.
- From May 2017 Penrice birth centre had operated on an on-call model, which meant it was not staffed after 8pm. When a woman booked to birth at Penrice was in labour at night, the on-call midwife would open up the birth centre to receive the woman. A second on-call midwife would join them to attend the birth.
- The ratio of midwifery staff to births at Penrice birth centre at the time of our inspection was one midwife to every 35 births. This was the agreed ratio for home and community birth in the trust and was in line with the planning tool. Midwives we spoke with felt the level of staffing was adequate for the number of births at and in line with safer childbirth. Community midwives on-call were part of the escalation plan to maintain safe staffing on the delivery suite at the Royal Cornwall Hospital when there were staff shortages or when there was a high than expected number of women in labour. Midwives working on the hospital wards were approached first, but if this was not enough a community midwife who was working 'on-call' for community births would be asked to work on the delivery suite. Community midwives had concerns about working in the delivery suite with high risk women. Community midwives and acute midwives did not all have the same training. Community midwives were trained in cardiotocography (CTG) interpretation which is used during pregnancy to monitor both the foetal heart and the contractions of the uterus. However, they were not trained in foetal monitoring using a STAN monitor which had been introduced in the hospital in the previous year. STAN is a type of monitor that uses computer analysis of the baby's heart rate and heart muscle function, to give clinicians a more accurate picture of how the baby is coping with labour The lack of training in STAN, and in other computer systems used in the delivery suite, put community midwives at a disadvantage as they were not trained to support high risk births. We did not see a plan for community midwives to have STAN training.
- Midwives at the birth centre told us that if they were called to work at night as part of the escalation plan, they still had to work their shift next day and there was

no formal back up plan to provide cover. However, the head of midwifery said this situation should not normally happen because the established process was that community midwives on call were either rostered into a day off or to have a working day with no clinical commitments to allow flexibility regarding callouts. The service wide data showed no community midwife had worked a whole shift in the previous two months; the longest escalation time had been 5.35 hours in May 2017. However, the working time at the hospital did not include travel time, which meant a midwife called out would be on duty longer than this.

- A common incident reported was the impact on midwives as a result of the diversion of triage calls from the Royal Cornwall hospital. There were 28 reports of occasions when midwife at the hospital was too busy to take triage calls, and diverted these to Penrice midwives. Which undoubtedly added to their workload?
- Midwives did not have community specific skills and drills training. The trust confirmed that two community midwives were to undertake an appropriate course in October 2017 to become trainers. After that they would be able to offer skills and drills training that was more reflective of the community setting. There were no plans in place for the interim.
- To protect women's and baby's safety, the birth centre would not be opened out of hours when the on call community midwife was diverted to work in the Royal Cornwall Hospital's delivery suite. Trust guidelines required two midwives to be present for delivery.
- In 2016, midwives raised concerns about barriers in understanding between hospital and community midwives. As a result some rotation was planned to help midwives gain experience of different roles. The community midwives we spoke with had mixed views on rotation, some did not want to incur travel costs or spend time in a role other than what they considered their specialist role, but others welcomed the opportunity.
- The trust had an in-house bank of temporary staff including midwives who were used to fill gaps in staffing due to sickness or other absence.

Medical staffing

- As a standalone midwife-led unit, there were no medical staff on the premises However, midwives reported good communication with obstetricians at the Royal Cornwall Hospital and were able to refer women identified as having risk factors from co-morbidities or other concerns identified in antenatal visits, to a consultant.
- Some obstetricians held antenatal clinics in the community, although no consultant clinics were run at the Penrice centre.

Major incident awareness and training

- Staff were aware of how to access the trust's major incident plan. There was no evidence of fire evacuation tests having been carried out, either in reality or as a desk top exercise. Staff confirmed they had not been involved in practical drills to evacuate the birth centre building but that they understood the action to take in the event of fire.
- All women planning home or birth centre births were warned there could be occasions when the service could not support community births although they would do their utmost to do. Women were then advised to birth their baby in hospital.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- There was no audit plan for community midwifery to provide assurance of effective delivery of care in line with trust guidelines in antenatal or postnatal care or birth at home or in Penrice birth centre.
- The transfer rate from home or birth centre was higher than the national average. The absence of accurate data and case reviews meant the reasons for this was not investigated. Community midwives reported some difficulties in persuading their colleagues in the day assessment unit or the delivery suite to take referrals.
- There were gaps in available guidance for community midwives: no written guideline for community midwives on baby weight loss, on managing community obstetric and neonatal emergencies or on MEOWS. Community midwives did not have remote access to the guidelines.

- Guidelines had not been amended to reflect the fact that there were no longer statutory supervisors of midwives. This source of advice had not been replaced by a new referral protocol.

However

- Policies and procedures in place followed national guidelines.
- Pain relief was provided through low intervention methods like water (hydrotherapy), massage, TENS machines, gas and air and occasionally Pethidine. The service was provided seven days a week.
- The service had full accreditation (Stage 3) from the UNICEF baby friendly initiative to encourage breastfeeding.
- The trust achieved a much higher community birth rate than the national average.
- The hospital took part in national maternity audits, including the new RCOG National Maternity and Perinatal Audit (NMPA), of which the hospital had been part of the pilot, and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).

Evidence-based care and treatment

- Policies and procedures for the wider trust were in use in the birth centre and by the community midwives. These had been developed in line with National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. Centrally, obstetricians and midwives had reviewed many hospital maternity guidelines to check adherence to the national guidance. The community midwives were not usually themselves involved in reviewing guidelines except those specific to community births such as the guideline on 'Water birth'.
- There were some guidelines specific to community midwives such as 'Still birth in the community', 'guidance on bilirubin measurement of the neonate within the community setting' and 'midwifery led pregnancy care and community birth '. There was evidence that the use of midwifery guidelines was being promoted to midwives and other staff through training days. However, community midwives did not have remote access to maternity guidelines although they had received paper copies. Remote access the online guidelines was planned with a new system for autumn 2017. Staff had recently received new laptops in anticipation of this
- Penrice Birth Centre staff followed trust maternity guidelines for antenatal and postnatal care which referenced NICE Quality Standards 22 (antenatal care) and 37 (postnatal care). First time mothers would normally have nine antenatal visits and mothers with a child already would have seven appointments. Women identified by a midwife as higher risk would have more appointments, including appointments with an obstetrician. Women had three postnatal visits. However, we were told that limitations of staff time and the manual effort needed to extract information from the outdated database used to store maternity patients information meant little auditing had been undertaken. There was no direct auditing of the quality of notes, for example to ensure that antenatal care was carried out in line with trust guidelines and that the number of visits performed met these thresholds.
- Midwives emphasised the importance of foetal movement to mothers at antenatal appointments to check the well-being of the baby. This was in line with RCOG guideline 57. Where a community midwife had concerns about foetal movements, women were referred to the day assessment unit at the Royal Cornwall Hospital where they would be assessed and seen by a doctor if necessary. However, there were no audits undertaken of referral to indicate if they were appropriate or not.
- Women with risk factors for gestational diabetes were offered glucose tolerance testing.
- The maternity service was taking part in the Growth Assessment Protocol, a national programme to improve patient safety by identifying small babies at risk. Midwives were following guidance on measuring fundal height from 24 weeks to estimate the size of the baby.
- Midwives at Penrice followed the trust guidelines: 'Water birth and the use of water during labour and birth' which were based on RCOG/ Royal College of Midwives (2006) Immersion in Water during Labour and Birth (RCOG/Royal College of Midwives Joint Statement No. 1) alongside the RCHT clinical guidelines for the management of each stage of labour.
- Staff followed recommended practice in assessing and managing neonatal jaundice in the first two weeks of life in line with NICE quality standard 57 and midwives we spoke with understood the thresholds for referral for therapy.

Pain relief

- Midwives asked women to consider pain relief as part of the birth plan which midwives helped women develop. Activebirthequipment was available to support women to change positions and remain mobile during labour to help withpain reliefand support a normalbirth. Other pain relief was available through low intervention methods such as water and massage. In addition, women could be given pethidine and/or nitrous oxygen and oxygen mix. Local anaesthesia was administered for the repair of perineal trauma. However, no audit of the effectiveness of pain relief was undertaken.

Nutrition and hydration

- Women and their partners could access the kitchen area and obtain tea or coffee as required. In addition, partners and family members could bring food prepared at home into the birth centre.
- Community midwives advised mothers birthing at the centre about breastfeeding. Wherever they had given birth, midwives offered support to mothers with breastfeeding and could signpost women to local breastfeeding peer support groups. Midwives were also aware of a new Public Health campaign to help mothers with breastfeeding advice promoted by Cornwall Council. Maternity support workers also provided breastfeeding support.
- The maternity services held full accreditation (Stage 3) from the UNICEF baby friendly initiative in 2014. This meant staff had implemented breast feeding standards that UNICEF had assessed and supported mothers to establish breastfeeding.

The trust did not have a guideline on weight loss in babies. Staff said community midwives would refer a baby with 10% birth weight loss or more to the neonatal unit. Women were offered same day outpatient referral.

Patient outcomes

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity clinical dashboard to monitor outcomes in a maternity service. We reviewed the maternity dashboards for 2015/16, 2016/17 and April and May 2017. The dashboards showed the number of births and the number of bookings for birth at Penrice birth centre, but did not provide detail on transfers or labour outcomes such as tears or haemorrhage.
- Incidents such as perineal tears were not monitored separately for home or community births, so there was no information available for trends to be identified and actions put in place.
- The overall community birth-rate was 11.4% which was much higher than the national average of 2.4%. The dashboard showed that of 542 community births in Cornwall in 2016/17, 22% of women were transferred into the hospital maternity unit. However, the accuracy of this figure depended on whether the midwife had reported the transfer on the electronic reporting system. We were not confident in this figure because the trigger for reporting was for emergency transfers and not all transfers. The service did not specifically analyse outcomes for women transferred to the maternity unit from the community for themes.
- In 2016/17 records showed that 69 first time mothers attended Penrice for delivery of which 48 were transferred (70%) to hospital for delivery. 25 of the 149 mothers who already had a child, needed transfer to hospital (16.7%). Generally, the transfer rate for women expecting their first baby is much higher than for those who have had a baby before. However, the most recent national comparator, the Birthplace national cohort study2011, found that 36.5% of women having their first baby transferred in labour. For women having a second or subsequent baby the transfer rate was 9.4%. Midwives said the woman's safety was paramount when taking decisions about transfer because of the travel involved and potential delay in getting emergency ambulance response.
- A 2016 audit carried out by the supervisors of midwives 'Intrapartum transfer' which had looked at records had shown that all transfers had been appropriate. It did not differentiate between first time mothers and those with children already. However, we could not reconcile the data in that audit (which showed 198 community births and 51 transfers) with the data on the maternity dashboard which showed 172 births and 23 transfers in that period, so were unsure of the validity of the findings.
- We reviewed an audit (April 2017) about labour and delivery in the community that related to reasons for transfer from home or birth centre to the Royal Cornwall Hospital in 2016. The audit showed that there were no inappropriate transfers and no poor care. The main

reason for transfer to hospital was failure to progress in labour (32%); other reasons were post-partum haemorrhage (15%), maternal observations (13%) and foetal distress (13%).

- We also reviewed a document called 'Community transfer audit'. The figures for transfer on this record showed 26 transfers whereas the maternity dashboard showed 20 transfers in the same period. Again, this brought into question the validity of figures and the accuracy of data collection. This audit did not review the women's notes against trust guidelines to provide assurance that midwives were following guidance correctly, and there was no evidence of analysis. We noted that the trust's own home birth guidance for women understated the current transfer rates, quoting 36-45% for first time mothers and 9-13% for mothers who had had a baby before.
- Between April 2016 and March 2017, there were 78 water births. Some midwives from the acute unit had been seconded to Penrice to learn about water birth, in advance of the availability of water birth at the hospital.
- A 2016 audit had shown that all babies born at Penrice Birth Centre had their temperature taken within an hour of birth, which was better than the score for the delivery suite in the Royal Cornwall Hospital.
- The maternity dashboard did not report specifically on babies born before a midwife arrived. However, the incident report showed that there were some babies born without a midwife. There was a protocol for the midwife to attend and undertake a risk assessment as to whether remaining at home or transfer to hospital is the most appropriate plan for that woman and baby. We saw that some babies and mothers were transferred to the maternity unit on the basis of maternal or neonatal observations.
- The maternity service took part in national maternity audits, including the new RCOG National Maternity and Perinatal Audit (NMPA), on which the Royal Cornwall Hospital had been part of the pilot, and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).

Competent staff

- All new staff underwent a formal induction programme that lasted for four days. This included an introduction to the trust, the maternity service and senior staff, mandatory training and safeguarding training. We were told that rostering was arranged so midwives new to community working were supervised by a more experienced staff member over the first few weeks. No newly qualified midwives worked in the community.
- Community midwives worked across antenatal, intrapartum and postnatal care, providing the full range of midwifery care in the community. However they were not trained to work in the hospital delivery suite, although occasionally called in to work there as part of the escalation process. Rotation so that midwives could develop skills to work across the service as a whole was under consideration.
- Some midwives took up opportunities to develop their skills through secondment. At Penrice birth centre three midwives had been seconded from the hospital to develop skills in low intervention births including water birth.
- Penrice midwives were able to refer women before and after birth to specialist midwives for antenatal screening, diabetes and infant feeding.
- Training needs identified from incidents, complaints and claims were incorporated in training sessions as needed. For example, addition training was delivered help midwives support women who had learning disabilities.
- Community midwives received training to ensure consistency of foetal measurement as part of the Growth Assessment Protocol, a national programme to improve patient safety in maternity care by identifying small babies at risk. Some midwives had also attended a training day on childbirth emergencies in the community. Midwives reported the training they received was good quality.
- Seven midwives at Penrice were trained in Newborn and Infant Physical Examination (NIPE), a check between 24 and 72 hours after birth, and carried out these checks for women in their area. There was a rolling programme of training and other midwives were in training at the time of the inspection. NIPE checks were a new remit for maternity from April 2017 as GPs were no longer commissioned to do this.
- There had been no review and risk assessment of the skills that lone working midwives needed in life threatening emergencies. In discussion with the senior management team we learned that midwives in the community relied on paramedics to provide cannulation. At the time of the inspection 11% of

community midwives were competent to cannulate. This was a risk to women living in geographically distant areas as a delay in ambulance arrival would delay the patient receiving potentially lifesaving treatment.
- Immediately following our inspection, the trust acknowledged the need for cannulation training for community midwives. The matron asked all community midwives to complete online training as soon as possible and to book a supervisory practice date. The matron would monitor compliance.
- Staff we spoke with said they had an appraisal in the past year. The trust-wide maternity service data for May 2017 showed 96% of midwives had an appraisal in the past year. The target was 100%.
- A rota of on-call senior midwives had replaced supervisors of midwives on-call after statutory supervision had ceased to exist in April 2017. The hospital had set up a local practice programme for midwives needing support with practice. Monthly group supervision was available to all midwives. Managers told us this was well-attended. The department were not piloting the new model of clinical supervision, called A-EQUIP (Advocating for Education and QUality ImProvement) which was expected to be rolled out nationally after the pilot.

Multidisciplinary working

- Meeting notes and the 2016 Midwifery Cultural Review both noted some barriers between community and hospital midwives. We observed, and saw documentary evidence of some poor joint working between community and hospital midwives in the day assessment unit and the delivery suite. Community midwives we spoke with said it was sometimes difficult to persuade their colleagues in the day assessment unit or the delivery suite to take a referral from the community.
- Midwives told us they got round the obstructions by making calls at different time to find someone more responsive to speak with. This was not efficient, and a working group was being set up to investigate tensions between community based and acute midwives.
- Community midwives could access support for women with mental health concerns from the perinatal mental health team from another trust. There was support for women with learning difficulties from the Royal Cornwall hospital's learning disabilities' service.
- Some midwives were based in GP practices so had regular contact with GPs.
- Midwives encouraged women to stop smoking and could signpost women to smoking cessation groups in GP surgeries and other locations.
- There were pathways for midwives to refer women, with their consent, to the Early Help Hub and Family Nurse Partnerships.
- The trust had liaised with the ambulance service and reached an agreement for community midwives to request a purple (category 1) emergency response in an immediately life threatening obstetric situation. This meant any ambulance called under this category would not be diverted to other serious incidents. The trust did not collect data on ambulance response times. Midwives told us they would report delays on the incident reporting system, though it was not clear what would constitute a delay.
- Paramedics from the ambulance service attended some training with midwives on obstetric emergencies in the community.

Seven-day services

- The birth centre was available to women 24 hours a day, seven days a week for labour and delivery.
- Women had contact details for their named midwife and a 24 hour contact number for the on-call midwife if they had concerns about pregnancy or were in labour. All calls were triaged centrally (either at the hospital or Penrice depending on the time of day).
- Antenatal and postnatal appointments were held Monday to Friday.

Access to information

- Pregnant women carried their own hand held records, which were started at the booking appointment. After the baby was born, a new record was made for the baby. The trust wide maternity information system held some electronic information.
- Booking for tests such as screening for abnormalities or referrals to obstetricians were made through the hospital's electronic maternity information system. Midwives who ordered tests were responsible for checking results. Low risk test results were posted to women and entered on the hand held notes at the next appointment. Copies of scans were inserted into women's hand held notes and a copy filed in the hospital record.

- Staff told us the existing electronic information system in maternity had only basic functionality needs. The trust was procuring a replacement system due to be introduced in the autumn. Staff were being issued with new laptops to enable access to the new system which would allow the maternity service to record more data on the system and provide a greater potential for analysis.
- Community midwives handed over information about mother and baby to health visitors and to the GP when postnatal care was complete. As part of the NIPE midwives completed baby's clinical record and the child's Red book (a national standard health and development record given to parents at the child's birth).
- The bereavement midwife explained she reviewed the notes of all women who had experienced pregnancy loss and prepared a 'suggested next pregnancy management plan' with women, which was documented in a woman's notes. Women were offered a copy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the need to seek consent for examining women. Staff told us they had had undergone training in how to assess capacity to consent and demonstrated a working knowledge of the Mental Capacity Act (MCA) and its implications.
- Midwives told us that they informed all women of the risks of delivery in a standalone unit, the lack of medical assistance and the process for transfer to the Royal Cornwall Hospital if required to ensure that they consented in the light of potential risks.
- In dealing with young people, midwives we spoke with understood that, in law a 16 year old was presumed to have capacity and able to consent or refuse to treatment in their own right. If they had concerns that any woman lacked capacity they would assess their capacity to consent and record it in the hospital notes, as well as being alert to possible safeguarding concerns.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- We saw from feedback that many women commented favourably about their experiences giving birth at the birth centre and their partners appreciated taking an active part in giving support during birth.
- Women reported that their birth plans were followed and they had good support about breastfeeding afterwards.
- Women reported being well informed of the risks of delivery in a standalone unit, including the length of time needed for emergency transfer by ambulance.
- Specialist midwives, for example for diabetes helped women understand their care during the antenatal period.
- Midwives were aware of the range of women's cultural, social and religious needs and responded to these in a personalised way.

Compassionate care

- We did not speak to any women who had given birth at Penrice as we did not meet any at the centre, although we heard from women who had antenatal appointments that midwives were compassionate, sensitive and supportive.
- Midwives and maternity support workers we spoke with showed awareness of the range of women's cultural, social and religious needs and how to respond to individual differences.
- The Friends and Family Test is a measure of patient satisfaction. Feedback for community postnatal care across Cornwall for May 2017 showed 100% of women would recommend postnatal care. The trend report showed satisfaction had fallen to 90% in January and March 2017 but otherwise had been high. However, the response rate was low at between 5 and 10%. Community midwives did not always give women the Friends and Family question on antenatal care to complete.
- The results of the CQC maternity survey did not differentiate between services; therefore, it was not possible to review satisfaction for the birth centre alone.

- The feedback the Birth Centre had received over the past year on its Facebook page was consistently positive, and women who had given birth at the centre sharing experiences in turn increased other women's confidence in choosing this model of care.

Understanding and involvement of patients and those close to them

- Women attending antenatal appointments said midwives had given clear advice about options for giving birth and gave them the opportunity to ask questions, as well as giving them information to take away to help in decision-making and time to make decisions.
- We spoke with three women in the postnatal ward who said they would like to have used the birth centre. They told they had discussed with their midwife both the possible risks of delivery in a standalone unit, and the length of time emergency transfer by ambulance could take.
- Women who had been referred to specialist midwives, such as for diabetes, said they had a good understanding of how to manage their condition to benefit their baby.
- Partners were supported to help women with their labour and birth.

Emotional support

- Women had continuity of care before, and after birth from a small number of community midwives which enabled them to establish trusting relationships.
- We spoke with two parents who reported that midwives were reassuring when they were worried about something.
- Midwives assessed women's mood during antenatal visits and were able to signpost women to sources of help for anxiety and depression. A perinatal mental health team from another trust supported women affected by moderate to severe mental health illness in the antenatal and postnatal period.
- Bereavement support was provided by a specialist bereavement midwife based at the hospital who provided sensitive and compassionate advice to women or couples, as well as practical support. She told us she contacted all parents who experienced a loss.
- There was a guideline for community midwives on sensitive management of a stillbirth in the community. This could include viewing the baby, a blessing or baptism service and assistance with making memories of the baby.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to needs of local people with clinics occurring near to women's home and choices available on where to give birth.
- Penrice Birth Centre had spacious and relaxed surroundings and was suitably equipped with a birthing pool, and a range of active birth aids.
- Systems were in place to enable women to be transferred to the delivery suite at the Royal Cornwall Hospital in the event of a problem.
- Women had access to a translator and to documents in braille and in other languages.
- Staff offered parent education in the antenatal period and breastfeeding support after the baby was born.
- All women had a named midwife and had antenatal and postnatal care from a team of midwives.

However:

- Since May 2017 the birth centre was only open on request out of hours, and staff shortage meant only one woman could labour at the unit out of hours.
- Women and their partners could not stay at the centre overnight, which had been an option before staffing reductions and was valuable for women in establishing breastfeeding.
- Many of the trust leaflets for women were not available electronically.

Service planning and delivery to meet the needs of local people

- The maternity service in Cornwall was designed to avoid women having to travel too far for appointments.

Women living in North Cornwall could have their antenatal and postnatal care at the base of their nearest community team, including Penrice if that location was the most convenient for them.

- The maternity service worked within the 'Commissioning strategy for maternity services 2014 – 2019' which covered a shared vision for the South West Peninsular. The Kernow clinical commissioning group covered Cornwall specifically and produced some information for new parents.
- All women had a named midwife and were seen by a small team of midwives. If a low risk woman requested obstetrician led care this was arranged.
- Community midwives discussed the place of birth with women at booking on the basis of the hospital's 'Choices in pregnancy and birth' leaflet. At subsequent antenatal visits they discussed the options in more detail including birth at Penrice Birth Centre. Women choosing to have their baby at the Birth Centre had an antenatal appointment at around 34 weeks to ensure suitability and to draw up a birth plan. This provided an opportunity for women to clarify what facilities are available and what would happen if there was a need for transfer in labour.
- The birthing rooms at Penrice birth centre had a relaxed feel. Each room had en-suite facilities. Furniture including chairs and chests of drawers gave a homely feel to the rooms. The drawers were for women's use but also held spare towels and clinical equipment
- Antenatal education was part of routine midwifery care and community midwives had time allocated for parent education. Three week pre-birth classes were run in children's centres throughout Cornwall. The purpose was to increase the knowledge, confidence and aspirations of expectant mothers and their partners.Midwives, children's centre staff and health visitors delivered these. Community midwives had time allocated for parent education.
- No recent local surveys of women's expectations of maternity services had been undertaken. However a Facebook page for the Penrice Birth Centre gave information to women about service, including photographs of babies born there and comments from mothers. Mothers commenting on Facebook had almost unanimously given the centre a five star rating.
- The trust had a catalogue of leaflets on a range of topics such as gestational diabetes, your choice: pregnancy and birth, postnatal exercises, and staying overnight on the postnatal ward. Midwives gave leaflets to mothers at appointments at different stages of pregnancy. However, only a small number of the leaflets were available electronically on the trust website.

Access and flow

- Women could refer themselves to the midwifery service or be referred by a GP or other health professional.
- Women were encouraged to make their first antenatal appointment between 8-10 weeks of pregnancy to ensure there was sufficient time to make an appointment for the 1st trimester ultrasound scan. Women had to attend the Royal Cornwall Hospital for scans. We saw from the maternity dashboard that 91% of women booked before 12 weeks but the dashboard did not have information on the number booking before 10 weeks to link to the antenatal screening pathway (NICE standard 1 - access to antenatal care, updated guidance February 2014). A community midwife carried out triage for women in the area in the daytime. Out of hours, women called the hospital switchboard that would transfer the call as appropriate to the day assessment unit or to a community midwife.
- If a woman needed to be transferred to hospital by ambulance from the birth centre, the community midwife accompanied them to provide continuity and support.
- Following the loss of postnatal overnight beds at Penrice in April 2017, midwives felt some women mistakenly assumed the Penrice Birth Centre no longer opened at night. Community midwives were seeking to improve women's understanding of the change.
- There had only been one occasion in the past year when the centre had not been able to accept a woman in labour because no midwife was available.

Meeting people's individual needs

- Women could visit the birth centre as part of their consideration of where to give birth. The decor in the birth rooms was simple and homely. Wooden furniture helped create an atmosphere that was relaxing and non clinical. There were different options for women to choose for lighting, a music player to play their own choice of music, television and facilities for making beverages.
- Women called their midwife if they went into labour during the day or the switchboard after 8pm. Out of hours the on-call midwife met the woman and their

partner at the birth centre. A second midwife would attend to provide support around the time of the birth so that one midwife looked after the mother, and one looked after the baby. The majority of women who wanted to give birth at Penrice were able to do so, whatever the time of day unless the on-call midwife was called to work in the hospital or if midwives were busy with other community births.

- Some antenatal visits could take place in women's homes if it was difficult for women to come to Penrice or a GP surgery for antenatal care.
- Until May 2017, the birth centre had two comfortably furnished rooms where women could stay after the birth. However, following the decision not to staff the unit permanently at night, these two rooms were taken out of use. Women and their partners could stay at the birth centre for up to two hours after birth which we considered a short time if there were problems with establishing breast feeding. Staff reported this had not presented a problem but the new model had only been in operation for three months.
- Some midwives offered aromatherapy treatments in line with a trust guideline.
- Midwives followed up women who missed appointments in line with the trust 'Did not attend or booked late for antenatal care' policy. If a woman missed an appointment the midwife would try to rearrange the appointment, but if there was no response would carry out an unannounced home visit, and contact the GP and health visitor if they could not contact the woman at this stage. After three failed attempts to make contact with the woman the midwife would decide a plan with the Community team leader, and alert the safeguarding team.
- Since May 2017 the birth centre was only open on request out of hours, and staff shortage meant only one woman could labour at the unit out of hours.
- Maternity support workers could visit mothers at home to provide breast feedingadviceand new born baby care support. The maternity support workers ran breastfeeding clinics at Penrice.
- Tongue tie release was available at Penrice to help with babies having difficulty feeding. This was in line with NICE guidance.
- Midwives could refer women with mental health issues or with learning disabilities to support from hospital services, social care and sometimes charities such as Addaction (for drug and alcohol misuse). Midwives told us they could refer women to a same day acute GP service for deep vein thrombosis. This is a serious condition that occurs when a blood clot forms in a vein located deep inside the body. This was to avoid women travelling to the hospital.
- There was a significant group of Jehovah's Witnesses in Cornwall and staff checked the woman's view on the use of blood products at the booking appointment. Midwives referred women to a Specialist Anaesthetist Clinic if they intended to decline blood products.
- In the event of a stillbirth or neonatal death women were offered the opportunity for cytogenetic testing in order to advise parents about future pregnancy.
- If a woman had an intrauterine death they could choose to birth at home or in the community after a full discussion about the risks, benefits and alternatives. Midwives would draw up a plan of care to support the woman and her family. More often women chose to use the Daisy suite in the Royal Cornwall Hospital.
- If a woman did not have English as her first language and wanted leaflets in another language or in large print, braille or an audio version she could obtain these from the Patient Advice and Liaison Service (PALS) Health Information Link. A telephone translation service was also available, and interpreters could be engaged with advance notice.

Learning from complaints and concerns

- Information about how to give comments or report concerns was available to women and families in the birth centre in a trust leaflet entitled 'Listening, responding, improving'. There had been no complaints about Penrice.
- Staff told us that if a woman attending a midwife appointment had a concern they would seek to resolve it at the time, and said it was generally possible to achieve a solution face to face.
- Staff were aware of the themes of maternity complaints in the service as a whole between April 2016 and March 2017: the top two themes were communication, failure to communicate in a timely way and failure to communicate compassionately.
- There was no separate analysis of community complaints.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Requires improvement

We rated well-led as requires improvement because:

- There was no written vision for the Penrice birth centre or a vision and set of values for community midwifery services.
- Community midwives were rarely consulted about midwifery policy, including where changes in the way of working that affected them directly.
- A number of risks such as ambulance delays and whether all community midwives had the skills to deal with some emergencies while awaiting an ambulance were not on the risk register at the time of the inspection.
- There was no local risk register for the birth centre. Midwives had raised their concern about one risk, lone working, with their team leader but this had not been escalated further.
- Penrice birth centre did not carry out audits on outcomes for women and babies which meant they could not provide assurance of effective practice.
- Although the trust's lone working policy followed up to date guidance on health staff working alone, midwives at Penrice were not confident in the mitigating arrangements put in place to ensure their safety in the new model of working.

However:

- A respected community midwife led the North Cornwall team (one of three community midwife teams in Cornwall) was based at the centre and oversaw day to day activities and managed staff.
- The team leader ensured an effective flow of information to community midwives about midwifery developments in the hospital.
- The seven members of the community midwife team at Penrice that we spoke with were enthusiastic about their work. They had welcomed the recent Listening into Action events which encouraged them to share practice and contribute to change in a way not previously possible.
- Staff were keen to further publicise the birth centre to the wider population to increase the number of women accessing the service, as well as encouraging home birth.

Leadership of service

- The community matron provided clinical leadership and guidance for all three community midwifery teams in Cornwall. The head of midwifery and the matron for community services provided senior management support. This post was vacant at the time of the inspection, but an appointment had been made and the post holder started the week after our inspection.
- The full time Band 7 community team leader oversaw the day-to-day running of Penrice Birth centre and regional midwife team and managed staff in the North region. Staff described the manager as dedicated and supportive.
- The Chief Nurse was the Board champion for maternity services and the head of Midwifery had access to the Board through her.

Vision and strategy for this service

- Midwives we spoke with described a vision of choice of place to give birth and women-centred care. However, there was no written strategy for the standalone birth centre at Penrice which had recently started to operate on a new model with fewer staff. Nor was there a community midwifery vision or strategy.
- The policy in Cornwall, set out in the trust's home birth guideline, was to offer midwife led care to women with an uncomplicated pregnancy and including the option of birth at home or in the community which was in line with the recommendations the National Maternity Review 'Better births', 2015.
- A co-located birth centre was due to open at the hospital in the autumn. Midwives anticipated that the opening could lead to fewer women choosing to give birth at Penrice, at least in the short term.

Governance, risk management and quality measurement

- The governance processes did not ensure quality, performance and risk were managed. Governance, risk management and quality measurement of the centre was included within the governance of the overall maternity service of the Royal Cornwall Hospital, where governance meetings took place. A divisional meeting took place monthly which reviewed finance and strategy. No minutes were taken of discussions at this meeting although an action log was maintained, and added to after each meeting. There was a monthly

obstetrics and gynaecology directorate meeting with a set agenda including ratifying guidelines, reviewing clinical dashboards, finance, risks and SIs. Meetings had a formal action log with named individuals to take forward actions. A matron and the head of midwifery represented midwifery at these meetings.

- The maternity clinical dashboard presented data relating to births across the maternity service as a whole. Penrice data fed into the wider trust perform performance, activity and incident data but the dashboard contained little information about community births. This meant that it would not be immediately apparent from the dashboard if there were a hotspot or emerging issue clustered in one area. There was no community maternity dashboard to provide oversight of community safety and performance.
- The main maternity meeting was a maternity forum held every two months. At this meeting there was evidence of a review of the maternity clinical scorecard, although no specific focus on improving the red and amber scores. There was some discussion of risk themes though the quality of data collection and the lack of audit data meant some themes would not be easily identified. The notes of the April 2017 meeting showed the standard agenda items were all discussed. However at the June 2017 meeting some standard items were not discussed, for example there was no community midwifery update, no update on the new maternity information system or NIPE update which meant staff had to wait another two months for information about these. The maternity forum feedback was reported on at the obstetric and gynaecology meeting, but the only feedback recorded in the minutes was that the meeting had been well-attended.
- The operational decision-making group for midwifery was the monthly senior midwives team meeting. The lead midwife for Penrice attended this meeting. We saw from minutes of meetings that the group discussed community issues, particularly on-call arrangements, and the recent diversion of triage telephone calls to Penrice staff. Staff told us they had feedback from these meetings through their team leader. Meetings such as this and the bi-monthly maternity forum (which the team lead also attended) were open to all midwives but community midwives did not often attend because of travel time and work commitments.
- There was no audit of the services provided at Penrice birth centre or of antenatal or postnatal care in the region. Nor were there documentation audits to review quality and ensure that all relevant checks were carried out in the antenatal and postnatal period. We were told a documentation audit would be introduced in November 2017.
- The service lacked a comprehensive audit program to provide oversight and assurance of systems and practices.
- Some of the trust midwifery guidelines were seen to be contradictory. For example, the trigger list for incident reporting said staff should report emergency transfer into the hospital from the community. This is what midwives were currently reporting. However, the community birth guideline said any transfer was a trigger for a reportable incident, which would be in line with national practice.
- The head of midwifery was responsible for ensuring risk management policies and procedures were in place within maternity services .The risk midwife reviewed all maternity incidents and ran weekly meetings to review the more significant incidents. We saw that any complex incidents affecting women who transferred to the hospital from Penrice were included in these discussions. There were two such incidents since January 2017.
- It was not clear how risks to the service were effectively managed. There was no local risk register for Penrice birth centre, and no risks for the birth centre or for the community midwifery service on the hospital risk register.
- One local risk identified by midwives related to lone working. This had become a greater risk since the change to the on-call model and the closure of overnight beds at Penrice birth Centre. Midwives said they had raised this as a concern but it had not been risk assessed and was not present on the risk register.
- A risk newsletter was emailed each month to all midwives to share learning from incidents. We saw copies on display on noticeboards. A link midwife from each of the three midwifery teams was nominated to attend the monthly risk management forum to report back to their teams, which was good practice. However in talking with staff we did not consider that all understood and were aware of their own roles in identifying and minimising clinical and non-clinical risks.

- Monthly practice development newsletters kept staff up to date and provided a focus for discussion at local safety briefings and team meetings.

Culture within the service

- The staff at the birth centre appeared to work as a close knit team. Staff clearly liked working at the birth centre and relationships were good among colleagues, although we were aware from documentation that there had been some tensions between staff in the past. The team was made up of some longstanding community midwives, midwives seconded from Royal Cornwall Hospital, student midwives and maternity support workers. Concern about the culture in the hospital-wide maternity services in 2016 had led to a review by a senior independent maternity adviser. This review, known as the 'Midwifery Culture review', was carried out in May 2016 and involved observation, discussions with staff and a staff survey. The midwives we spoke with did not recognise the poor morale and bullying described in the report. However, they did acknowledge that managers made strategic decisions centrally and the views of community midwives were rarely sought.
- Staff described a number of initiatives taken since the culture review, which had given staff opportunities to raise any concerns about the service, and become involved in changing the culture. The initiatives had included Listening into action workshops run between October and December 2016. Such workshops are a well-recognised approach used in the NHS for listening to staff and supporting them to make the changes they would like to see in the way the service works.
- The Royal College of Midwives had also run behaviours workshops and had reported observing some improvement in attitudes. Staff at the birth centre considered the discussions over the past few months were helpful in engaging staff in sharing practice and welcomed being able to suggest changes. They had previously felt it was hard to pass their views up the line to senior managers.

Public engagement

- The Penrice Birth Centre had a welcoming Facebook page with photographs of women and babies and comments from women who had used the service. Facebook was a medium well-used in Cornwall and was used by other hospital services too, such as the neo-natal unit
- However, there was limited public engagement in the maternity services as a whole in Cornwall. The former Maternity Service Liaison Committee (MSLC) had not operated for some time. There was an intention to re-launch this as Maternity Voices.
- Midwives acknowledged that the geography of Cornwall made it difficult to bring together a wide range of views on what women wanted in their antenatal and postnatal care so staff could design the service around women's needs.
- Midwives started 'The Happy Birth Project', to appeal for funds to improve the hospital maternity ward environment for women and families. This enabled the refurbished post-natal ward to have wall decorations, improvements to the day rooms on both wards, mood lights for the delivery rooms and birthing balls, mats and other aids. There had also been improvements to Penrice birth centre environment through this project. Flowing from this, 'Project 55', was a user group bringing together staff and volunteers to design aspects of the new alongside birth centre in the year leading up to its opening.

Staff engagement

- Prior to the cultural review, staff engagement had been very limited. Whilst this had begun to change, midwives were disappointed not to have been more involved in the decision not to staff the centre permanently at night.
- Some midwives felt that concerns escalated to their local manager were not always passed on to senior managers.
- A number of staff had taken part in a workshop in July 2017 ('Whose Shoes', based around a board game) which included the managerial teams, midwives, community midwives and women, to capture women's experience of using the maternity services. This acted as a culture building session and a set of actions for all staff to complete. Staff spoke highly of this and said it had gone some way to breaking down the barriers between them.

Innovation, improvement and sustainability

- Penrice Birth Centre offered women a choice where they could have a natural birth in spacious and relaxed surroundings. Midwives were planning how to further

publicise the centre to the wider population to increase the number of women using the birth centre. Women commenting on their birth centre experiences on the Facebook page used the tag 'Penrice and proud'

Outstanding practice and areas for improvement

Outstanding practice

The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there is a review and full risk assessment of lone working arrangements under the new model of care when the first on call midwife attends the birth centre.
- Identify, analyse and manage all risks of harm to women in maternity services, ensuring local risk registers are maintained in all discrete units and feed into the divisional and corporate risk register.
- Ensure all midwives update their training to a level where they all have the skills needed for their roles, and set targets for completion of training in line with trust targets of 95%.
- Ensure better quality data about processes and outcomes within the maternity services is available for analysis and to support improvement.
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures are effective. Ensure audits are aligned to incidents and identified risks.
- Ensure the maternity dashboard includes sufficient information to provide a comprehensive overview of maternity performance. Proactively benchmark processes and outcomes in the maternity service against comparable trusts in rural areas.

Action the hospital SHOULD take to improve

- Consider developing a community specific dashboard display to give a comprehensive overview of community maternity performance. .
- Clarify whether midwives should record all intrapartum transfers from the community as incidents.
- Review the back-fill arrangements when midwives working on call have to work at night to ensure they are fit to work their shift next day.
- Consider how the vision and strategy for the birth centre and community midwifery are documented and communicated.
- Develop clear written guidance for midwives about maternal observations, managing community obstetric and neonatal emergencies, baby weight loss and feeding concerns.
- Develop policies and guidelines with more involvement of a range of relevant staff, particularly those who will need to implement the policy or are affected by it.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;** **Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because;** • The quality and accuracy of performance data was not adequate and data was not was poor and data was not used to identify trends or areas for improvement. • The information management system for the maternity service did not hold the information needed to run an efficient service • The service had not identified all risks or provided adequate mitigation for some of the risks identified • There was limited audit activity to review for the quality of processes in maternity and for improvement or benchmarking • The risk of lone working had not been fully risk assessed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way for all service users, and not all risks were identified and mitigated effectively. Some staff did not have the skills to care for women and babies safely.**

This section is primarily information for the provider

Requirement notices

Some midwives in the community were not confident in cannulation and potentially not able provide basic life support in the face of ambulance delays to remote communities/birthing centres.