Northumbria Healthcare NHS Foundation Trust

Berwick Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	Good
Maternity and gynaecology	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Berwick Infirmary is one of the hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This hospital provides community inpatient beds; an urgent care centre and midwifery led maternity service. We inspected community in patient and urgent care services as part of our comprehensive inspection of community services as this trust; these services are reported within separate inspection reports. This report specifically relates to maternity services at this hospital.

Northumbria Healthcare NHS Foundation Trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. The trust has operated as a foundation trust since 1 August 2006.

We inspected Berwick Infirmary as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, Northumbria Specialist Emergency Care Hospital, North Tyneside General Hospital, Wansbeck General Hospital, Hexham General Hospital, and community services. We inspected maternity services at Berwick Infirmary on 11 November 2015.

Overall, we rated maternity and gynaecology services as good, with well-led rated as requires improvement.

Our key findings were as follows:

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15 at this hospital.
- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff.
- Patients received care in a clean, hygienic and suitably maintained environment.
- There were cleaning schedules in place across all wards and departments which were fully completed in line with cleaning requirements and the trust's policy.
- There was adequate personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection.
- There were sufficient staffing levels to meet the needs of women. There was a ratio of midwives to births of 1:24, which was better than the ROCG guideline of 1:28.
- There was no medical staff based at this maternity unit, however a consultant led clinic was held fortnightly for women with a high risk pregnancy.
- There was a robust midwifery led care policy, which identified the criteria for women being able to deliver within the unit and at home.
- Women were provided with tea and toast following delivery. There was no formal food service due to the nature of the unit and small number of births.
- Staff interacted with women in a respectful way. Women were involved in their birth plans and had a named midwife.
- Women received an assessment of their needs at their first appointment with a midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as necessary. The midwives were available, on call, 24 hours a day for births as needed.

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

Importantly, the trust must:

- Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

In addition the trust should:

Summary of findings

- Ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Consider reviewing the provision of hearing screening services in the remote parts of the trust, to meet the needs of the local community.
- Consider a formal programme of staff rotation to provide assurance of clinical competence.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity and gynaecology	Good	Overall we rated maternity services as good, with well led as requires improvement because: Staff were aware and were confident in the reporting of incidents, data supplied by the trust showed no reported incidents between June 2014 and July 2015. There were sufficient staffing levels to meet the needs of women. The unit was clean and staff complied with infection control guidelines. Staff used the maternity early warning scores to assess risk and women were transferred to the consultant led centres, if their scores became elevated or concerns were identified in labour. There were guidelines in place for managing normal labour which had clearly defined criteria for transfer. Care and treatment was planned and delivered in a way to ensure women's safety and welfare. The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Patient outcomes were monitored and action taken to make improvements. Staff interacted with women in a respectful way. Women were involved in their birth plans and had a named midwife. There were processes in place to ensure women received emotional support where required. We found there were procedures in place to ensure that patients were seen at the right place at the right time. Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to. Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the

Summary of findings

directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality. The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice

Berwick Infirmary

Detailed findings

Services we looked at
Maternity and gynaecology;

Detailed findings

Contents

Background to Berwick Infirmary

Berwick Infirmary is a small community hospital located within the town centre of Berwick upon Tweed.

Services provided at this hospital include; inpatient services for elderly medicine, stroke and orthopaedic rehabilitation and palliative care; a minor injuries unit which is open 24 hours and supported by GPs; and a midwifery-led maternity unit with single delivery room and birthing pool and pre-assessment facilities.

There are plans for a new facility, to be built on the existing Berwick Infirmary site, which will give space to improve integration between health and social care services, delivering more joined-up care for local people.

Maternity services at Berwick Infirmary were based in a purpose built midwifery led unit with no medical care apart from a fortnightly consultant clinic. Following some incidents the unit closed and the service consulted on services provided from the unit. The maternity unit reopened using a new model, which consists of an antenatal clinic staffed 08.30 to 18.00 Monday to Friday; and 09:00-14:30 on Saturdays, Sundays and bank holidays. An out of hours on call midwifery team provides intrapartum care for low risk cases. The unit provides antenatal clinics for low and high risk women and intrapartum care for low risk women only but not including in-patient overnight stays.

Geographically there is 57 miles between the Infirmary and the Northumbria Specialist Emergency Care Hospital (NSECH) and 52 miles between the Infirmary and the Wansbeck General Hospital.

At the Berwick Infirmary there was an average of nine deliveries a year.

The Unit had one delivery room which had a birthing pool and active birth equipment. There was one home from home room and an antenatal clinic.

During our inspection we reviewed all services based at the Berwick site. We spoke with one patient and their relative, as well as five staff (which included midwives), health care assistants, a domestic and a doctor. We observed care and treatment and looked at the storage of care records. We also reviewed the trust's performance data.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, Consultant Physician.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included a CQC inspection manager, 23 CQC inspectors and a variety of specialists including: a non-executive director, Director of Nursing, consultant anaesthetist, consultant physician and gastroenterologist, consultant in obstetrics and

Detailed findings

gynaecology, consultant obstetrician and specialist on feto-maternal medicine, accident and emergency nurses, paramedic, nurse consultant in critical care, palliative care modernisation facilitator, head of midwifery, risk midwife, infection control nurse, surgical nurse, matron, head of children's services and junior doctor. We also had experts by experience that had experience of using healthcare services.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations included the local clinical commissioning groups, NHS England, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 11 November 2015. We held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the hospital, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We held listening events on 22 October and 6 November 2015 in Alnwick, Hexham, Cramlington and Whitley Bay to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Facts and data about Berwick Infirmary

Northumbria Healthcare NHS Foundation Trust serves the population of Northumberland and North Tyneside, a population of around 500,000. The trust has operated as a foundation trust since 1 August 2006. During 2014/15,the trust saw 71,000 patients on wards, carried out 36,476 operations and is responsible for 1.4 million appointments with patients outside of its hospitals.

The health of people in Northumberland is varied compared with the England average. Deprivation is lower than average, however about 17% (9,300) children live in poverty. Life expectancy for women is lower than the England average.

The health of people in North Tyneside is varied compared with the England average. Deprivation is higher than average and about 19% (6,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

Northumberland was ranked 135th and North Tyneside was ranked 113th most deprived out of the 326 local authorities across England in 2010.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Maternity and gynaecology

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

Information about the service

Maternity services at Berwick Infirmary were based in a purpose built midwifery led unit with no medical care apart from a fortnightly consultant clinic. Following some incidents the unit closed and the service consulted on services provided from the unit. The maternity unit reopened using a new model, which consists of an antenatal clinic staffed 08.30 to 17.00 with community midwives on call for upcoming births.

Geographically there was 57 miles between the Infirmary and the Northumbria Specialist Emergency Care Hospital (NSECH) and 52 miles between the Infirmary and the Wansbeck General Hospital.

At the Berwick Infirmary there was an average of nine deliveries a year.

The Unit maternity had one delivery room which had a birthing pool and active birth equipment. There was one home from home room and an antenatal clinic.

During our inspection we reviewed all maternity services based at the Berwick site. We spoke with one patient and their relative, as well as five staff (which included midwives), health care assistant, domestic and a doctor. We observed care and treatment and looked at the storage of care records. We also reviewed the trust's performance data.

Summary of findings

Overall we rated maternity services as good, with well-led as requires improvement because:

Staff were aware and were confident in the reporting of incidents, data supplied by the trust showed no reported incidents between June 2014 and July 2015. There were sufficient staffing levels to meet the needs of women. The unit was clean and staff complied with infection control guidelines. Staff used the maternity early warning scores to assess risk and women were transferred to the consultant led centres, if their scores became elevated or concerns were identified in labour. There were guidelines in place for managing normal labour which had clearly defined criteria for transfer. Care and treatment was planned and delivered in a way to ensure women's safety and welfare.

The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Patient outcomes were monitored and action taken to make improvements.

Staff interacted with women in a respectful way. Women were involved in their birth plans and had a named midwife. There were processes in place to ensure women received emotional support where required.

Maternity and gynaecology

We found there were procedures in place to ensure that patients were seen at the right place at the right time. Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. The risk register did not reflect the current concerns of the senior management team. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality. The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice

Are maternity and gynaecology services safe?

Good

We rated the safe domain as good.

There were guidelines in place for managing normal labour which had clearly defined criteria for transfer. Care and treatment was planned and delivered in a way to ensure women's safety and welfare.

Staff were aware and were confident in the reporting of incidents.Data supplied by the trust showed no reported incidents between June 2014 and July 2015. There were sufficient staffing levels to meet the needs of women.

Staff followed guidance for infection, prevention and control. The unit was clean and staff complied with infection control guidelines. Staff used the maternity early warning scores to assess risk and women were transferred to the consultant led centres, if their scores became elevated or concerns were identified in labour.

Incidents

- There were no incidents reported between August 2014 and July 2015.
- Staff we spoke with were aware of the principles of the duty of candour, however, could not recall an occasion where it needed to be used.
- The service used a weekly safety bulletin to inform staff of learning and changes to practice and keep staff informed of the risks which faced the directorate. We observed the bulletin was displayed in clinical areas; staff we spoke with informed us that the bulletin was discussed at team meetings.
- There were no Never Events reported for maternity and gynaecology in 2014/15.
- Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by staff and reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from March 2015 to May 2015 included examples of the steering group reviewing cases and recommending changes to clinical

guidelines and practice as a result. Staff informed us they would like to attend these meetings, however, due to the distance of travel and levels of sickness this has not been possible.

Safety thermometer

- Maternity had started using the national maternity safety thermometer. This allowed the maternity team to check on harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar score (a method to quickly summarise the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.
- The service participated in the pilot for the national maternity safety thermometer. Results showed for combined harm free care between November 2014 and October 2015 between 52% and 87% of women received harm free care, however this was not benchmarked against other trusts.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- At the main entrance to the unit, visitors were encouraged to wash their hands with antibacterial foam. Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.
- Cleaning rotas were in place for domestic staff and these were complete. We observed staff cleaning clinical areas during our inspection.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure relevant patients were managed on the correct care pathways. Data between 2014/2015 2015 showed 100% of women had been screened for HIV and Hepatitis B.
- During our announced inspection we found inconsistent practices in the storage of placenta's, we raised these concerns with service leads During our unannounced inspection we were provided with assurance that storage and collection practices of placenta's was now consistent across all services.

Environment and equipment

- The maternity unit had one delivery room, which had a birth pool and active birth equipmentWe found that the temperature of the delivery room was 20 degrees and felt cold; however, staff assured us that the room warmed up as required.
- ENTONOX® (nitrous oxide and oxygen) was not piped directly into the delivery room, however, was available in cylinders, however, this was not secured to the wall, however, was secured in a trolley stand.
- All equipment was stored and checked appropriately.
- There was a resucitaire in a separate room, however, this could be moved into the delivery room if staff were concerned or women delivered quickly before ambulance transfer would arrive.
- There were clinic rooms and also beds for women and their partners should they want to stay for a few hours after the birth or if the baby was born late in the evening.
- The maternity unit provided antenatal assessment of fetal wellbeing using a CTG; however, the age of the machine meant that it did not have the Dawes/Redman criteria for automated fetal heart rate analysis (2011). Using Dawes Redman criteria is not a replacement for clinical judgement; however, computerised analysis ensures consistency of interpretation. We were told this had been escalated to the Head of Midwifery (HOM) and action was being taken.
- All portable appliance tests (PAT) were up to date.

Medicines

- Medicines were stored in locked cupboards.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All of the fridge temperatures were checked and recorded daily.

- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Records showed controlled drugs were checked in line with hospital policy.

Records

- The service was in the process of transition between paper records and electronic records. At the time of inspection antenatal records were completed electronically, however, delivery and postnatal records were still paper records.
- The trust also retained a separate set of records which were held in the women's local base hospital and these were transferred to Wansbeck hospital at 36 weeks of pregnancy in preparation for delivery.
- The service kept medical records securely in line with the data protection policy.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the North East Personal Child Health (NEPCHR) 'red book' which was given to women following the new-born examination.
- The service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- We reviewed an annual supervisor of midwives (SOM) audit of record keeping dated October 2014. A review of 25 patient records identified improvements were required in four areas, these were:
  - Basic record keeping.
  - Antenatal records.
  - Labour records.
  - Postnatal care.
- We reviewed the November 2015 SOM record-keeping audit which reviewed 27 health records and found improvements had been made; however, some areas had reduced in performance for example clients details on all pages had reduced from 100% compliance in 2014 to 85% compliance in 2015. Evidence of birth plan discussion had reduced from 100% to 73%. If CTG was used in labour hourly fresh eyes documentation had reduced from 70% to 50%. The postnatal checklist completed by midwife and evidence of health visitor handover had both reduced from 100% to 67%. The audit showed actions taken immediately by the SOM during review, however there was no detailed action plan, although there were recommendations arounddiscussion documentation compliance in the annual SOM review and also the SOM mandatory training sessions.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children, following a serious case review in June 2014.
- The safeguarding plan sits in the back up medical notes and the care plan was based in the electronic notes, which meant staff had access to plans if the paper records were unavailable.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- There was no site specific mandatory training information for Berwick; however, staff we spoke with informed us that all safeguarding training was completed.
- We were informed that the safeguarding midwife would attend the unit to undertake supervision with the staff in line with the trust policy.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness.
- A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patients health record; there was a clear process in place to facilitate this reporting requirement.

Mandatory training

- Midwifery staff attended a two-day obstetric PROMPT mandatory programme, which included emergency

drills, adult and neonatal resuscitation, infant feeding, record keeping and risk management awareness. Staff we spoke with informed us that mandatory training was monitored by SOM and Team leaders.
- There was no site specific mandatory training information for Berwick, however, staff we spoke with informed us that all staff were up to date with their mandatory training, and all staff received training on the advanced life support in obstetrics (ALSO) and neonatal life support (NLS).

Assessing and responding to patient risk

- There were no doctors in the birthing centre which was midwifery led. Where consultant input was required because of complications in labour women had been transferred by ambulance to the acute hospital. There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth or the midwifery led unit to hospital and transfers postnatally to NSECH.
- There was a robust midwifery led care policy, which identified the criteria for women being able to deliver within the unit and at home. Staff informed us as soon as they were concerned they called for an emergency response ambulance.

Midwifery staffing

- Information provided by the service identified a ratio of midwives to births of 1:24, which was better than the ROCG guideline of 1:28.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported the percentage of women given one-to-one support from a midwife was good.

Medical staffing

- There were no medical staff based at the maternity unit, however a consultant led clinic was held fortnightly for women with a high risk pregnancy.
- Staff informed us if they were concerned they were able to contact a consultant at NSECH for advice.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.
- The trust had major incident action cards to support the emergency planning and preparedness policy. Staff understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Patient outcomes were monitored and action taken to make improvements.

Staff had the correct skills, knowledge and experience to do their job. Training ensured midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.

Information was freely available in the form of leaflets, for instance, about pain relief. However many were out of date. There was advice and support for women about nutrition and hydration during pregnancy.

Patient outcomes were monitored using the maternity dashboard not all patient outcomes were within expectations; however, we saw that investigations were underway in areas of concern.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.
- From our observations and through discussion with staff, care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.

Maternity and gynaecology

- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32.
- There was evidence to indicate NICE Quality Standard 37 guidance was being met. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, we observed guidance on neonatal resuscitation and a pathway dictating which service to contact namely the tertiary referral centre or NSECH.

Pain relief

- Women had access to a number of pain relief options, these included, Entonox in portable cylinders, narcotics, active birth equipment and a birthing pool. Women were not able to use the birthing pool overnight, as there were not the required three members of staff to evacuate the pool in the case of an emergency. Women who laboured at night and wanted to use the water had to travel to the Hillcrest Maternity Unit at Alnwick.
- The service reported that it promoted hypnobirthing as an alternative method of pain relief and we were told two midwives within the service were trained in this technique. Women were signposted to support in the local community.

Nutrition and hydration

- There were two infant feeding coordinators; their role included training staff, supporting breastfeeding mothers on the postnatal ward and the community.
- Breastfeeding initiation rates for deliveries that took place in the trust for April 2015 to June 2015 were reported as 61%, which was above the trust target of 60%. Data showed that 51% of babies were still breastfeed at discharge from the hospital and 37% of babies were still breastfeed at discharge from maternity care.
- The trust was implementing United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved stage two of the accreditation process, however, were unsuccessful when the service was assessed for stage three of the accreditation process.
- Women were able to spend all day at the maternity unit; this enabled them to have support with a number of breast feeds.
- Women were provided with tea and toast following delivery.Staff informed us that a tradition had begun of calling the restaurant in the main hospital for bacon sandwiches. There was no formal food service due to the nature of the unit and small number of births.

Patient outcomes

- The unit had 100% normal vaginal delivery rate, which was better than the national average of 60%.

Competent staff

- The head of midwifery, matron and team leaders allocate staff to training through appraisal. The appraisal rate was 96% for 2014/2015. All staff we spoke with informed us their appraisal was up to date.
- We were told the PROMPT training programme for obstetrics ran over a two-year cycle, which ensured a comprehensive training programme. Subjects included, antenatal and newborn screening, and public health initiatives. The training programme also included skills drills in subjects such as cord prolapse (including at home) and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage.
- Healthcare support workers attend PROMPT training to support the delivery of services and examples of subjects included the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- All midwives had a named supervisor of midwives (SOM). Staff we spoke with told us they had access to and support from an on call SOM 24 hours a day. The ratio of SOM to midwives was one to 11 which was in line with recommendations. The 2014/15 local supervisory authority (LSA) report identified that SOMs needed to negotiate enough protected time to undertake statutory work, and also consider new models for supervision. We did not see any action plan relating to this.
- There was no SOM based within the team, however, staff informed us they felt well supported and knew how to contact the on call SOM.

- Staff we spoke with informed us that due to staff shortages staff were unable to rotate to NESECH to maintain clinical skills. Staff informed us that this was a valuable exercise, and were missing the opportunity to update with clinical skills.

Multidisciplinary working

- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.
- The health visitors and the community midwife team worked together to identify and report potential risks to hospital staff, risks were notified by health visitors, and community midwives had access to pathways about vulnerable women.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.

Seven-day services

- The unit opened between 08.30am – 18.00pm Monday to Friday and 09.00am– 14.30pm on Saturdays, Sundays and bank holidays. An out of hours on call midwifery team provides intrapartum care for low risk cases.

Access to information

- Women who used the maternity services had access to informative literature. We saw examples on display, such as whooping cough in pregnancy, smoking cessation, pathway through labour and optimal infant nutrition.
- Copies of the delivery summary were sent to the GP and health visitor to inform them of the outcome of the birth episode.
- The maternity unit had its own version of the trust corporate branding. The unit also had its own dedicated area on the trust website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity. 92% of staff had completed MCA level 1 training.

Are maternity and gynaecology services caring?

Good

We rated the caring domain as good because:

During our inspection we were only able to speak with one woman and her partner. We observed staff interacted with women in a respectful way. Women were involved in their birth plans and had a named midwife. There were processes in place to ensure women received emotional support where required.

Compassionate care

- Following a number of complaints received in 2014 at Wansbeck Hospital, the service introduced a programme of compassion training which was offered to all staff. Staff informed us that originally they felt it was unnecessary, however, following the training all staff said they found it extremely valuable.
- Results from the Maternity Service Survey 2015, showed the service scored better than other hospitals in five of the 19 questions about labour andbirth. For antenatal and postnatal care, the service scored the same as other trusts.
- There was no friends and family test data for this location due to the low number of responses, however, trust wide data showed between July and September 2015 an average 98% of women would recommend their birth experience; this was better than the England average at 97%. Staff proactively promoted patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.

Understanding and involvement of patients and those close to them

- We noted the rate of home births was low (below 1%). Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwives, and the consultant team were also involved

in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.
- Women were involved in their choice of birth, at booking and throughout the antenatal period. Women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby. All women we spoke with were aware of which pathway they were following (High or Low risk).

Emotional support

- Women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss were supported by the Health Psychology Service; the outcomes of this service were reported as good. This was a well-established service and patients self-referred or were assessed and referred by staff. Patients were contacted promptly, appropriately assessed and redirected offering early engagement and reassurance to this patient group.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good because:

The service had a consultant led clinic which meant that women did not need to travel to see a consultant. The service continually exceeded the target set for booking appointments before 12 weeks gestation (weeks of pregnancy).

Staff were aware of how to book translation services for appointments; however, these were often cancelled by the translation service with short notice.

The service had a number of specialist midwifery roles to support women for example a high risk midwife and diabetes midwife specialist.

Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Service planning and delivery to meet the needs of local people

- The service held a fortnightly consultant clinic for all women who required consultant led care, which meant they did not have to travel to Wansbeck.
- Scan services were provided from the Berwick Infirmary, and women were able to be reviewed in the maternity unit as required.
- Antenatal clinics were held daily, clinics were also held weekly from two GP surgeries in rural areas.
- Women previously had access to hearing screening in the maternity unit, however, this had changed and women had to travel 45 minutes in a car or two and a half hours by public transport to Alnwick. We were informed that this has been escalated to the HOM; following our inspection we were informed the Head of Midwifery raised this issue with the manager of the newborn hearing screening and that the issue was discussed at the Governance meeting and minuted and fed back to staff. The hearing screening service had decided to centralise the service at Alnwick because of the low number of patients. It was agreed to monitor user feedback and notify the newborn hearing screeners of any concerns raised by the service users. Staff we spoke with during our inspection were not aware of this information.
- Women who required closer surveillance during pregnancy had to go to the Pregnancy assessment unit at Wansbeck, which was one hour 15 minutes by car and two hours by bus.
- Breastfeeding support for women at Berwick was provided from the unit. Women were able to stay during the day and received continued support.

Access and flow

- Between April 2015 and September 2015 the service achieved 86% of bookings appointments before 12 completed weeks' gestation which was just below the trust target of 90%.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as necessary. The midwives were available, on call, 24 hours a day for deliveries in the unit and home births.

Meeting people's individual needs

Maternity and gynaecology

- Staff could explain how the translation service was accessed and used, however, we were informed that translation services often cancelled at the last minute and staff used language line, however, this was not ideal for booking appointments.
- Staff were trained to undertake the new-born examinations and 100% were completed within 72 hours of delivery.
- Staff had access to support from specialist midwives for example, in screening and diabetes.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and monitored monthly at the obstetrics and gynaecology governance group.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received; the PALS team supported this.
- Staff we spoke with informed us the service received no complaints between September 2014 and October 2015

Are maternity and gynaecology services well-led?

Requires improvement

We rated the well-led domain as requires improvement because:

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team.

The engagement of the senior team was focused at NSECH; staff based in Berwick had not met the Operational services manager since the commencement of the post.

The service had not benchmarked themselves effectively against the recommendations of the Kirkup Report (2015).

There were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality.

The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice.

Vision and strategy for this service

- Most staff were aware of the trust's vision and were committed to embedding the improvements both in maternity and gynaecology services and as part of the trust as a whole.
- The senior management, midwives and consultants were all committed to their patients, staff and unit. The vision of the unit was to provide the best outcome for women through promoting normality and high quality care and to become the "provider of choice".
- Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities.

Governance, risk management and quality measurement

- The maternity risk management strategy set out guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality care was reported and improved. The risk management strategy had not been reviewed to reflect the current service provision as it did not highlight the care provided at NSECH.
- The maternity incident review group was chaired by the consultant on call or by the obstetric delivery suite lead and reviewed clinical Incidents. This group collated a summary of incidents which then escalated concerns to the obstetrics and gynaecology governance group (OandGGG) chaired by the head of midwifery (HOM). The

aim of the group was to look at any areas for concern in practice and to identify trends and determine what actions should be taken to avoid a similar incident in the future.

- A clinical governance coordinator reviewed and responded to risks on a daily basis. A quarterly report was produced from incidents, data from the birth register and key performance measures that were monitored on the maternity services dashboard each month.
- Learning was encouraged through further discussion at local meetings and memorandums and also one-to-one meetings where required.
- The service used the maternity dashboard recommended by the RCOG. The dashboard was a clinical performance and governance scorecard and helped to identify patient safety issues in advance.
- We found the dashboard contained inaccuracies, for example the number of instrumental, operative and vaginal births did not equate to 100%. This meant we were concerned with the accuracy and monitoring of the dashboard at all levels within the service.
- A maternity risk register contained 27 risks in total. It was updated on a monthly basis at the obstetrics and gynaecology operational management board meeting (OandGOMB). Risks included cost pressure, maternity IT systems, and latex sensitivity. We saw that the top three risks were shared with staff weekly in the safety bulletin. All staff we spoke with were able to inform us of these risks.
- There were systems and processes in place linking the statutory supervision of midwives to the local clinical governance and risk management strategy. Issues of risk and governance were discussed by the SOM team at their supervisors meetings.
- We received two Kirkup (2015) gap analyses from the service: the first was data prior to the publication of the report and the second was data following. However, the service only assessed itself against the recommendation applicable to the wider NHS and not against the recommendations made for the individual service named in the report.

Leadership of service

- The maternity and gynaecology service was part of the Surgical Business Unit.
- The structure that leads the maternity and gynaecology service is as follows: business unit director; deputy executive director; clinical director; general manager; head of midwifery; operational service manager (OSM); clinical Lead Midwife/matron; Acting Clinical lead midwife/matron Berwick and a matron for gynaecology. The day to day management of the unit is provided by the clinical lead midwife/matron who links in with the team leader and HOM and OSM and general manager.
- Across the service, there was a matron for gynaecology and one for maternity and an interim matron for community; however, due to the geographical spread the service required additional matron posts. We were informed two substantive matron posts had been advertised, one for the midwifery led units and one for community. It was expected that interviews would take place in December 2015.
- Staff said they received good support from local managers and were able to escalate and discuss concerns. They felt the matron was visible and approachable, however, rarely saw the HOM and had not met the OSM, since the commencement of the role.

Culture within the service

- We observed strong team working with medical staff and midwives working cooperatively and with respect for each others roles. They told us that the trust was a 'good place to work'.
- Staff sickness levels in maternity between June 2015 and August 2015 was 7% against a trust target of 3%. Some of these related to long term sickness.

Public engagement

- During a review of services provided bythe midwifery led unit in Berwick there was a large amount of engagement with local families to ensure services were appropriate tothe needs of the community for example, the senior team met with local leaders and held information sessions to inform women and their families about the new vision for the service.

Staff engagement

- There were no directorate specific results in the 2014 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored just short of 4. This score placed the trust in the highest 20% of trusts compared to similar trusts.

Maternity and gynaecology

- Staff informed us they were included as part of the directorate, however, often felt separated especially when decisions were made.
- Following our inspection we were informed that staff were invited to all forums including the MDT practice development meeting, Governance and team leaders meeting and are represented at these forums contributing Berwick midwives views to any discussion and decision made. Berwick midwives participate in the review of all guidelines to ensure that their views are represented. Also we were informed during the re-modelling of services at Berwick additional staff were put into the rotas to facilitate rotation to NSECH to update skills. This also gave additional staff to cover sickness and annual leave which is built into the rota and therefore does not require additional cover from NSECH to facilitate rotation. If staff do request rotation from a obstetric unit at NSECH to the Midwifery led units then this is facilitated. However, during our inspection this was not corroborated by staff. We were informed that there was no formal rotation of staff to NSECH due to sickness and maternity cover.

Innovation, improvement and sustainability

- The service had the support of a small health psychology team. This team supported women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss. The outcomes of the service were reported as good.
- The service implemented a series of workshops to equip staff with the necessary skills to enable them to deliver compassionate care by utilising appropriate communication skills and strategies with patients and families. The health psychology team delivered this, and following a review of the 2015 CQC patient experience survey, the trust was ranked within the top 10% for patient experience. This meant that the compassion training was improving patients experience of care and interactions with staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The service must complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- The service should ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Consider reviewing the provision of hearing screening services in the remote parts of the trust, to meet the needs of the local community.
- Consider a formal programme of staff rotation to provide assurance of clinical competence

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
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must: • Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust. • Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.