Royal Cornwall Hospitals NHS Trust

Helston Birth Centre

Inspection report

Helston Community Hospital
Meneage Road
Helston
TR13 8DR
Tel: 01326430200

Date of inspection visit: 6 and 7 December 2022
Date of publication: 27/02/2023

Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services well-led?	**Good**

Our findings

Overall summary of services at Helston Birth Centre

Good

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Helston Birth Centre

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

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

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

We did not rate this location at this inspection.

We also inspected two other maternity services locations run by Royal Cornwall Hospitals NHS Trust. Our reports are here:

Penrice Birthing Unit: https://www.cqc.org.uk/location/REF81

Royal Cornwall Hospital: https://www.cqc.org.uk/location/REF12

How we carried out the inspection

We inspected the service using a site visit and spoke with staff and managers. We interviewed leaders and members of the executive team remotely after the site visit. The service submitted data and evidence of their performance after the inspection which was analysed and reviewed for use in the report.

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

Maternity

Good

Maternity services at Helston Birth Centre include outpatient antenatal, intrapartum (care during labour and delivery), and postnatal maternity care. Services were delivered on the premises of Helston Community Hospital and were provided by Royal Cornwall NHS Foundation Trust. The midwifery led unit provides intrapartum care for women and birthing people who met the criteria and were assessed to have low risk pregnancies. The birth unit has one birthing room with a birth pool and en-suite facilities. There was one clinical room for pre-booked appointments. Helston Birth Centre was staffed by community midwives and midwifery support workers.

Intrapartum activity levels at the Helston Birth Centre were low. The trust reported 11 babies were born at the unit from April 2022 to November 2022, this represents under 0.5% out of 2548 total births in Cornwall during the same time period.

Women and birthing people could self-refer to the service online.

This was the first rating of the maternity services at this location. We rated it as good because:

- The service had enough staff to care for women and birthing people and keep them safe. Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services and all staff were committed to improving services continually. People could access the service when they needed it and did not have to wait too long for treatment.
- The service actively engaged with women and birthing people and families to improve services especially through use of their Maternity Voices Partnership and the local safeguarding team.

However:

- Daily checks were completed and documented but did not always identify out of date equipment.
- Staff appraisals were not up to date.

Is the service safe?

Good

We rated the service as good.

Mandatory training

Maternity

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

Data showed 86% of midwives and 84% of maternity support workers had attended the maternity update day. This was below the trust target of 90%. The trust overall had a focus on improving compliance with mandatory training at the time of inspection. Staff attended practical obstetric multi-professional training (PROMPT) days and compliance was 98% for midwives and 97% for maternity support workers.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders monitored mandatory training compliance through the monthly update in the maternity and neonatal safety report to board.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Mandatory training included modules in safeguarding, perinatal mental health, and human factors training. Senior midwives attended leadership courses in line with recommendations in the Ockenden Report (2022). We saw evidence that training was continuously evaluated and evolved with the needs of the trust, for example the trust had implemented training for staff on informed consent following results of an audit; 12 months following the initial implementation, the trust had devised content to build on the initial training and cover more in-depth cultural competency training, with a view to continuing developing training year on year. Practical Obstetric Multi-Professional Training (PROMPT) was conducted face-to-face with all levels of staff taking part. PROMPT days contained training on obstetric emergencies and newborn resuscitation; staff attended neonatal life support training from the resuscitation council every four years.

Team leaders in the community had recently created a training document for newly qualified midwives and midwives new to the community setting. This document clearly set out mandatory training required and dates of completion, as well as competencies and information required for safe and effective community working.

The service did not complete regular birth pool evacuation training or baby abduction drills. Staff received one-off training in safe evacuation of birthing pools. Data showed in 2022, 57 staff completed this training which was compliant with the trust target. Staff have access to pool evacuation procedure, instructions and visual aids on their intranet, including photos and videos of a successful evacuation. However, the service did not complete regular birth pool evacuation simulations at Helston Birth Centre. Since the inspection, the trust told us that birth pool evacuation is on the annual mandatory training programme.

Staff were required to complete medicines management training annually and overall trust compliance was 87.8%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

There was a comprehensive, up to date guideline for maternity training which contained a thorough training needs analysis taking into account recommendations from national reports and requirements from CNST.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training had been developed over a number of years at the trust in response to increasing numbers of safeguarding cases in the area. The safeguarding team consisted of specialist nurses and midwives who had close links with the local authority. They worked from a dedicated multi-disciplinary hub in order to provide joined up care for women and birthing people and families receiving support.

Staff were up to date in their safeguarding training and were trained to the appropriate level for their role. Safeguarding training consisted of mandatory updates and the safeguarding team provided bespoke training short courses lasting one hour that staff could access at times to suit them. Short courses covered topics such as the mental capacity act, correct referrals process, learning from local and national adverse events and many others. Each quarter there were five short courses available for staff to access. Short courses were developed by the local team in a responsive way to give staff access to current and topical best practice. Staff were able to request and suggest learning topics according to need in practice.

There was a safeguarding training passport to ensure staff accessed all the necessary training, and training was evaluated and updated on a regular basis to ensure high quality training was maintained. An overview of the safeguarding training package and training compliance levels were reported regularly to the board to ensure adequate oversight.

The trust had a well-established specialist team of midwives to support women and birthing people and families throughout pregnancy who required safeguarding involvement, provide continuity of care, and to provide knowledge and expertise to colleagues working both in the community and acute setting. Staff used a safeguarding chronology document to ensure all relevant professionals and services had access to contemporaneous safeguarding information about women and birthing people and families. Staff knew how to access this and were confident with its use. We saw evidence that staff updated chronologies regularly, and there were systems and processes in place to ensure chronologies were checked and maintained.

Community midwives had monthly supervision of safeguarding cases on their portfolios and felt well supported to provide care.

We saw evidence that the service responded to risks and adverse events and learnt from them, for example: when an area for improvement was identified, staff used debriefs, improved escalation processes, and reviewed when to refer women and birthing people and families appropriately. Learning was the disseminated to staff via training days and email communication.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There was a baby abduction policy in place to support staff in the aftermath of an abduction, however it was not clear what measures were in place to reduce the risk of an abduction taking place. The abduction policy had not been tested with staff at Helston Birth Centre.

Maternity

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after contact with women and birthing people and labelled equipment to show when it was last cleaned. For example, we saw staff used 'I am clean' stickers to show equipment was clean and ready to use.

Staff completed daily flushing of the birth pool.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The birth unit was secure. There was a buzzer entry and exit system.

Staff had access to a neonatal resuscitaire in the birthing room ready to use if needed. Staff carried out daily safety checks of specialist equipment on days when the unit was in use however, we found out of date equipment on the delivery trolley, and some parts of the emergency and delivery trolleys needed minor restocking. We escalated this to staff and it was immediately resolved.

Staff did not have access to adult resuscitation equipment at Helston Birth Centre, this had been risk assessed by the trust. In case of maternal collapse staff followed the emergency procedure, and risks were discussed with women and birthing people when planning place of birth.

Staff had access to safe equipment to evacuate a person from the birthing pool in the event of maternal collapse. Staff had access to an all-purpose patient transfer slide and flotation aids.

The service had suitable facilities to meet the needs of women and birthing people's families. The birthing room was en-suite with a birthing pool. Women and birthing people and birthing people had access to birthing balls and mats to support active labour. There was seldom-used equipment in place inside the birthing room for example: gym balls, chairs, excess equipment trolleys, pool evacuation equipment; this made the environment cluttered and difficult to mobilise around when in labour, and was a potential risk during emergency situations.

Staff disposed of clinical waste safely.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies and equipment was tested according to recommended timeframes.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration

Midwives at the Helston Birth Centre provided advice and support to women and birthing people antenatally but did not do triage assessments for women and birthing people in early labour. Women and birthing people in early labour were triaged through the Royal Cornwall Hospital maternity triage phone line.

Staff completed risk assessments for women and birthing people antenatally and throughout their pregnancy. Midwives used personalised fetal growth charts in line with national guidance. Women and birthing people and birthing people could access antenatal screening services at the main hospital site.

Staff assessed if women and birthing people were suitable to birth at the birthing unit at 36 weeks. No records were kept at the unit and therefore we were unable to verify this through audit. Notes from Helston Birth Centre were included in documentation audits done by the trust at the main site.

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birthing options clinic. This was staffed by a consultant midwife and consultant obstetrician to discuss risks and options available to create a suitable birth plan together.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used the maternity early obstetric warning score (MEOWS) to identify women and birthing people at risk of deterioration. Matrons completed MEOWS documentation audits. The January to March 2022 audit of 90 records from across the trust maternity service showed there was good overall compliance at 93%.

Staff completed risk assessments for each woman on arrival to the birth unit in labour.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments in relation to venous thromboembolism (VTE) and pressure area risks. Information was displayed on sepsis recognition and management in the community office.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Staff used a situation, background, assessment, recommendation (SBAR) format to share information. The last SBAR audit completed in November 2022 of 16 sets of notes selected randomly from across the trust maternity service showed the tool was used in 55% of cases and was not fully embedded in the maternity service.

Leaders monitored transfers from the free-standing midwifery led units into the labour ward on the main hospital site. The most recent transfer audit showed 1.9% of all births were intrapartum transfers from the community. There were no overall themes for women transferred during labour; some example reasons women and birthing people were transferred during labour were for pain relief, fetal distress, and postpartum haemorrhage.

Midwives based in the community did not always into the Royal Cornwall Hospital labour ward or the co-located midwife led birth centre. There was a risk due to the low levels of intrapartum activity at the centre, midwives would not be up to date on key skills such as suturing (stitching wounds) or cannulating (inserting a small tube into a vein for intravenous access). This was being reviewed within a trust-wide staffing consultation taking place at the time of inspection.

Maternity

The service had three safety huddles per day that were attended by maternity teams from within the main site, the community hubs and safeguarding teams to discuss activity, outliers, staffing, and any other concerns. Safety huddles were performed virtually to ensure all areas were able to access them. We saw evidence of effective communication and escalation pathways between midwifery and medical staff, and to managers where necessary. Staff told us that there was a flat hierarchy and they felt able to approach consultants and managers with any concerns. There was a high-level on-call system in place to assist managers with operational issues.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. However, appraisal rates were low.

The service had enough nursing and midwifery staff to keep women, birthing people and babies safe. Helston Birth Centre was open 9am to 5pm seven days a week. Overnight, the 3 freestanding birth units (Penrice, Helston and the Isle of Scilly) were staffed by community midwives operating an on-call system. The maternity service had three pairs of midwives available every night to support people requesting a community birth (home or birth unit). Midwives were sent to open Helston Birth Centre out of hours if required. The service managed staffing for community births via the maternity triage system.

Managers accurately calculated and reviewed the number and grade of midwives and maternity healthcare assistants needed for each shift in accordance with national guidance. The trust had utilised a standardised national reporting tool to calculate safe staffing numbers which showed a deficit across the whole trust maternity services of 16.07 whole time equivalent midwives as of March 2022. The service told us that ongoing recruitment was in place but there was a deficit of 10 whole time equivalent midwives at the time of inspection. Recruitment drives had been successful however staff had left due to relocation or retirement. The service was completing a consultation of staffing needs and analysis to reflect and maintain an efficient workforce. There were higher numbers of community midwives at the trust to reflect the rural geography of the local area. Managers told us that they aimed to build a flexible workforce to cope with changing needs within maternity services. The final results of the consultation were not yet known, but leaders told us that the aim was to staff the women and birthing people rather than the buildings, for example, moving midwives into the areas that are busiest at the time. Community staff told us that they had not been involved in the consultation as much as they wanted.

The number of midwives and healthcare assistants sometimes matched the planned numbers however we saw a deficit of midwives and maternity healthcare workers on the day of inspection.

The service had low and reducing turnover rates.

The service had reducing sickness rates. The maternity dashboard showed the sickness rate for community midwives was reducing and was 5% or less in the past three months September to November 2022. The service did not use agency midwives.

Managers supported staff to develop through yearly, constructive appraisals of their work, but appraisal rates were low at the time of inspection. Data showed appraisal rates across the maternity service were low. As of 6 December 2022, 57% of midwives had received an annual appraisal and 43% of midwifery support workers.

Records

Maternity

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. Matrons completed audits of basic record keeping. The December 2022 audit of 71 randomly selected sets of notes from across the trust maternity service showed compliance was 90%.

The service was updating the paper records used for care in labour at the time of inspection. A new booklet for care of women and birthing people in labour had been produced but was not yet in use.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Staff stored paper records securely.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes to prescribe and administer medicines safely. However, staff could not access the midwife's exemption list at Helston Birth Centre and the midwives exemptions were not clearly recorded in the trust medicines management policy.

Staff completed medicines records accurately and kept them up-to-date.

Incidents

Due to low activity levels, evidence of learning from incidents at Helston Birth Centre was limited.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Managers investigated incidents thoroughly. Women and birthing people and their families were involved in these investigations.

The trust had an overarching process for managing and reviewing incidents across maternity services in all locations.

The service had not had any never events.

Managers shared learning with their staff about never events that happened elsewhere and looked to external incidents to encourage learning.

Staff reported serious incidents clearly and in line with trust policy. The trust held weekly review meetings to discuss current cases and recommendations from the Healthcare Safety Investigation Branch (HSIB) and any serious incidents. The meetings were attended by midwifery managers, board level leaders including the chief nurse and speciality midwives. Learning and risk was identified and actioned quickly to improve care for women and birthing people without delay whilst awaiting initial feedback and final reports.

Maternity

There was evidence that changes had been made as a result of feedback, for example introduction of a hyponatraemia (low sodium levels in the blood) guideline to avoid and treat women and birthing people at risk, including women and birthing people that choose to birth in water.

Managers debriefed and supported staff after any serious incident. The trust had introduced training for staff psychological wellbeing following involvement in any traumatic event.

Is the service well-led?

Good

We rated the service as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Helston Birth Centre was managed as part of the Women's Children's and HIV services care group of Royal Cornwall Hospital. This care group was managed by a director of midwifery, a clinical director and a general manager. Staff we spoke with told us the director of midwifery had visited the birthing unit and was approachable.

On a local level, Helston Birth Centre was managed by the community matron, supported by 1 community team leader.

A non-executive director had visited maternity community services and the feedback from this visit was shard at the September 2022 maternity and obstetric business and governance meeting.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The service had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women, birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and had started to revise the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Maternity

There was a specific strategy for workforce recruitment and retention and progress was measured using key performance indicators embedded in the maternity dashboard and was reported to the local maternity and neonatal system.

Leaders and staff understood, knew how to apply the strategy and monitor progress. We saw evidence that a new strategy for maternity services was being developed for launch in 2023.

A business case was agreed and progressing to increase the capacity of the 'WREN' (Women (and birthing people) Requiring Extra Nurturing) team to ensure existing maternity continuity of carer focused on those living in areas of high deprivation and those from a black or ethnic minority background.

Culture

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

There was no information on how to make a complaint or raise concerns available on the unit. The maternity section of the Royal Cornwall Hospital website included a section on providing feedback to the service.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. There were no formal complaints relating to Helston Birth Centre or community midwifery care between 1 September 2022 and 5 December 2022. There was one informal complaint relating to community midwifery care in this period.

The community matron told us the culture between community staff and hospital-based midwifery staff was improving.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Helston Birth Centre was managed as part of the Royal Cornwall Hospital maternity governance structure. A monthly maternity and obstetric business and governance meeting reported up to the Royal Cornwall Hospital trust board.

We reviewed the minutes of the last two maternity and obstetric business and governance meetings for September and October 2022 meeting and found community activity was discussed at this meeting and the impact of pressure on the ambulance service on the number of births in community settings.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff had access to clinical guidelines on an electronic system. Clinical guidelines were the same across all Royal Cornwall NHS Trust sites. We reviewed two clinical guidelines: antenatal ultrasound scanning and the waterbirth guidelines and found these were up to date and in line with national guidelines.

Trust guidelines were reviewed every three years, or before if new national recommendations were made.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Managers monitored outcomes for women and birthing people and babies on a maternity dashboard. The dashboard contained minimal data relevant to Helston Birth Centre. The data that was relevant to the unit included: the number of births at Helston, the number of women and birthing people booked for birth at Helston, total births in the community, and number of intrapartum transfers from the community.

Helston Birth Centre did not have a local risk register. There were no risks on the trust maternity services overall risk register that related specifically to the Helston Birth Centre. Risks that related to community maternity services generally included a midwifery staffing risk and the ability of the ambulance service to respond to births in community settings, due to ongoing pressures and Cornwall's rural geography. Staff told us that their main risks in the community were births happening before arrival to the birth centres or a midwife arriving to attend a home address, completion of Newborn and Infant Physical Examination (NIPE) and newborn blood spot screening. These risks were recorded, acknowledged and monitored in governance documentation seen in the overall trust data submission.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used a combination of electronic systems and paper records to document care.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for managerial review, internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure. However, staff were required to access several different systems and paper records to find the information that they needed, which sometimes made work time-consuming. The trust had an 18-month programme in place for digital transformation in line with national recommendations. Leaders told us that a system had been selected and a digital midwife had recently come into post to drive the transformation.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Maternity

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care. The trust had an active MVP that was implemented in 2018; the MVP chair told us that they were well embedded into the service and that the trust was open in its engagement with the MVP and women and birthing people using the service in order to drive improvement.

The MVP was instrumental in drafting patient safety information on transfer times from rural areas into the hospital for women and birthing people to make informed choices regarding their preferred place of birth.

The service made interpreting services available for women and birthing people. The maternity service collected data on ethnicity.

Leaders understood the needs of the local population which included women and birthing people living in rural locations, a high number of safeguarding cases, and families on low incomes.

Staff at the trust worked closely with the local authority and external stakeholders to improve outcomes for pregnant women, people and their families, for example: organisations working specifically with young fathers, young mothers, and health visiting teams. We saw evidence of the trust working to reinstate schemes such as the family nurse partnership as a renewed need for the role had been recognised. Safeguarding teams at the trust had trained teams of community support workers to deliver extra packages of care to vulnerable families during pregnancy and ongoing support following postnatal discharge from maternity services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff at Helston Birth Centre had developed an induction package for newly qualified midwives and those new to community working to ensure clinical competency and provision of adequate individualised support when joining the community team.

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Maternity safety champions told us that listening to patient voices was integral to continued learning at the trust, and that extruding themes for learning was done by triangulating patient experience with reports, audits and outcome data.

Leaders encouraged innovation and participation in research. The trust employed a dedicated research for midwife for research, and local research projects were regularly led by senior midwives in house. The trust was participating in a national breech birth study at the time of inspection. The service collaborated with regional universities and charities to support research studies.

Maternity

Areas for improvement

Action the trust SHOULD take to improve:

Helston Birth Centre

- The trust should ensure that daily checks are completed and accurate, including ensuring equipment is checked for expiry dates and that trolleys contain necessary stocks of equipment.
- The service should evaluate current training provision for emergency evacuation of the birth pool and ensure birth pool evacuation simulations are carried out to ensure all staff are confident and proficient to carry out this procedure in an emergency.
- The service should ensure staff are aware of the baby abduction policy, the policy is strengthened to include preventative measures, and that staff of all levels are involved in live simulations.
- The trust should consider the facilities available and any ways to improve the space available to ensure the safest layout to provide care, including decluttering.
- The trust should ensure that clear documentation and guidance is available to staff regarding midwife exemption and patient group directive medicine.
- The trust should ensure all staff receive an annual appraisal.

Our inspection team

The team that inspected the service comprised a CQC inspector and a clinical midwifery specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.