County Durham and Darlington NHS Foundation Trust

University Hospital North Durham

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection 7 – 9 September 2016. This was a focussed unannounced inspection in response to external reviews carried out at the trust looking at serious incidents and concerns around the culture within maternity services. The external reviews were initiated by the trust following heightened scrutiny of maternity services and monitoring of the service internally. We looked at areas within the safe and well-led domains.

- There was an ongoing review of governance structures and quality assurance processes. The Trust had identified the need to enhance governance in the service and had appointed a new leadership team who were revising current practice. Actions were agreed with external partners, some having recently been implemented, but were not yet embedded.
- Assurance processes to ensure guidelines and practice was followed was not clear which led to confusion amongst staff and women. The assessment, compliance and approval of guidelines were included in the governance review.
- Although weekly risk meetings were held to discuss incidents and key message bulletins were produced to inform all staff of lessons learned, some staff felt that these processes could be stronger.
- The completion of the World Health Organisation surgical safety checklist was not meeting trust targets in all except one domain.
- There was a newly formed senior leadership team in maternity. The team was cohesive and there was a real drive to improve the quality of the service. The team were aware of the challenges and were able to articulate the actions required to take the service forward.
- Staff spoke positively about the leadership team and told us the head of midwifery was supportive and approachable. Plans were in place to strengthen clinical leadership.
- Staff were aware of the process to follow to report incidents.
- Recommended midwifery to birth ratios and consultant presence on the labour ward were met
- Results from the NHS safety thermometer showed that women had received harm free care over the last 12 months.
- Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed. There were appropriate escalation procedures for women requiring an emergency response. The early warning score for assessing risks had improved.
- The service had an action plan in response to the Morecambe Bay Investigation recommendations. The majority of these were completed with a few still partially completed due to ongoing re-organisation of the trust.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that the recent improvements to the governance framework are fully embedded to support the delivery of high quality care, including assessment, approval and compliance of guidelines.
- Improve compliance against the WHO surgical safety checklist.

In addition the trust should:

- Continue to implement the recommendations identified in the review of midwifery staffing to ensure the appropriate deployment of staff in the correct areas.

Professor Sir Mike Richards
Chief Inspector of Hospitals

University Hospital North Durham

Detailed findings

Services we looked at
Maternity

Detailed findings

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Our inspection team

The team included CQC inspectors and a variety of specialists: including a doctor in obstetrics, head of midwifery services and a midwife.

How we carried out this inspection

This was a focussed unannounced inspection in response to external reviews carried out at the trust looking at serious incidents and concerns around the culture within maternity services. We looked at areas within the safe and well-led domains.

We asked the trust to provide information, which we analysed during and after the inspection. We spoke with midwives, medical staff and senior managers in maternity services and the executive team. We spoke with women who used the service.

Maternity and gynaecology

Safe	
Well-led	
Overall	Good

Information about the service

The University Hospital of North Durham and Darlington Memorial Hospital provided maternity services for County Durham and Darlington NHS Foundation Trust. The maternity services offered at the University Hospital of North Durham consisted of antenatal, intrapartum and postnatal services. The service delivered 3362 babies between July 2015 and July 2016.

We carried out a focussed inspection in response to external reviews carried out at the trust looking at serious incidents and concerns around the culture within maternity services. We looked at areas within the safe and well-led domains.

We visited the labour ward (ward 8), the antenatal and postnatal ward (ward 10), the pregnancy assessment unit and antenatal clinic. We spoke with 20 members of staff and three mothers. We reviewed eight sets of records.

Summary of findings

Overall, maternity services at University Hospital of North Durham were safe and well led. There was a newly formed senior leadership team in maternity. We found that this team was cohesive and that there was a real drive to improve the quality of the service. There were no concerns around bullying or undermining behaviour.

Staff knew how to report incidents. We saw evidence from actions plans and root cause analysis that serious incidents were identified and investigated appropriately.

However, there did not appear to be a robust system to review cases at risk meetings and the completion of the World Health Organisation surgical safety checklist was not meeting trust targets in all except one domain.

Maternity and gynaecology

Are maternity and gynaecology services safe?

- Staff were aware of the process to follow to report incidents.
- Weekly risk meetings were held to discuss incidents and key message bulletins were produced to inform all staff of lessons learned.
- Recommended midwifery to birth ratios were met.
- Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed.

However:

- The review of cases at risk meetings did not appear systematic. There was no evidence of matching practice with guidelines and there was little discussion about learning points.
- The consultant on call for the labour ward also had to cover antenatal and postnatal, acute gynaecology, and accident and emergency.
- It was not clear how often skill drills took place on the ward.
- The completion of the World Health Organisation (WHO) surgical safety checklist was not meeting trust targets in all except one domain. Recommendations from an audit carried out in October 2015 included the introduction of an updated WHO checklist and re audit after the introduction; (scheduled for November 2016).

Incidents

- Staff we spoke with were aware of the procedure for electronic reporting of incidents. They said they were encouraged to report incidents and were confident to do so.
- Staff had access to an up to date incident management policy.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no never events reported between August 2015 and July 2016.
- There was one serious incident reported between August 2015 and July 2016. We reviewed the root cause analysis for this incident, which included lessons learned and an action plan.
- The patient safety midwife was able to describe the process for investigating incidents. Those incidents classed as moderate or serious would be discussed and the duty of candour process would be started. The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. A timeline would be produced for investigation, a duty of candour letter sent and root cause analysis (RCA) meetings held. A final report would be produced and lessons learned would be discussed at governance meetings.
- Risk meetings were held weekly to discuss incidents. Medical and midwifery staff attended these. Learning from these meetings was disseminated to staff through a key messages notice that was emailed to staff and placed on notice boards. We saw these notices displayed during our inspection.
- During our inspection, we attended a risk meeting. The review of cases did not appear systematic or based on guidelines. There was no evidence of matching practice with guidelines and staff present at the meeting were not aware of key areas of the guideline when asked. There appeared to be little discussion around the learning points. There was no clear pathway for when incidents, such as a postpartum haemorrhage, would become classed as a serious incident.
- Morbidity and mortality meetings were held every two months. We saw minutes from these meetings. The meetings were attended mainly be medical staff. An action plan produced in May 2016 by the trust, in response to an external review, recommended the service should consider ways to increase midwife presence at perinatal mortality meetings. However, some midwives said they did not have time to attend these on a regular basis. Three months of minutes showed that attendance from midwifery staff was improving.
- Minutes from governance assurance group meetings and patient safety meetings for the directorate were reviewed. Incidents were a standing agenda item. Staff were sent key message notices following these meetings. Plans were in place to start producing the key message notices cross-site.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer measures the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's),pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis. The maternity safety thermometer measures perineal and /or abdominal trauma, post-partum haemorrhage, infection, separation from baby, psychological safety and Apgar scores less than seven at five minutes.
- Results from the NHS safety thermometer were displayed on the wall and showed that women had experienced harm free care over the last 12 months.

Environment and equipment

- Access to the maternity unit was via a buzzer system. Babies wore electronic tags to prevent anyone leaving the unit with them without permission. The system had recently been tested and was found to work as needed.
- There was adequate equipment on the wards to provide safe care, including resuscitation equipment and cardiotocography (CTG) machines. Staff told us they had access to appropriate equipment when needed.
- The labour ward (Ward 8) had 10 en-suite delivery rooms including a birthing pool and a bereavement room used for women experiencing pregnancy loss. The birthing pool was situated in a corridor away from the rest of the delivery rooms. Staff told us varying reports about its use. It appeared to be used sub optimally due to the availability of staff and its location. The last time a skills drill for pool evacuation was recorded was Jan2015. Equipment was available in all rooms, such as resuscitaires, oxygen and suction. Some rooms had birthing balls available for use.
- The labour ward had its own obstetric theatre on the unit. This was used for emergency procedures and some planned cases. The hospital's main operating theatres were used for planned cases for two days a week.
- Ward 10 was for antenatal and postnatal care. This had 23 beds, which consisted of single rooms, two bed and four bed bays. They nursed babies that needed transitional care and could access support from the neonatal unit.
- The pregnancy assessment unit was situated next to the labour ward.
- Resuscitation trolleys were available on both wards and we saw that daily checks had been completed. The trolley for labour ward was kept in the pregnancy assessment unit waiting area. This meant that members of the public could access the trolley. Good practice would be for the trolleys to be locked with a tamper proof seal.
- We checked equipment to ensure it had been electrical safety tested. Out of 13 pieces of equipment we looked at, seven were overdue for their testing.

Records

- We reviewed eight sets of records. Overall, they were clear, accurate and legible. Risks assessments were completed and individualised care plans for pregnancy and labour were documented. However, there appeared to be a lack of formal organisation within the records and medical staff had difficulty navigating through them during the risk meeting.
- Women carried their own records throughout the pregnancy and hospital-based records supported these. Opaque record bags had been provided to women following a report in the local press that a patient's own notes had been left on the front seat of a car in a public carpark. Staff gave these to all patients at their first antenatal clinic appointment.
- We saw evidence of regular trust wide documentation audits looking at the quality of documentation and record keeping for emergency caesarean sections, electronic fetal monitoring, post-natal documentation, intrapartum documentation and personal handheld notes. These audits provided recommendations and action plans for practice.

Mandatory training

- Midwives, health care assistants and medical staff attended mandatory training yearly. This training included updates on key aspects of care as well as scenario based learning for obstetric emergencies and neonatal resuscitation.
- Skill drills were held on the ward, but most of the staff we spoke with said they had not been present at those held on the ward, but completed them during their mandatory training days. Records showed that the emergency drill for the birthing pool had last been run in January 2015.
- New training had started in a simulation centre, not all of the staff had attended these sessions yet.
- Eight staff had been funded to undertake practical obstetric multi-professional training (PROMPT) which is

an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.
- Staff had training on the sepsis bundle and were aware of the sepsis policy.
- Staff told us that they were given time for their training and very rarely had to cancel. Training was on a rolling programme so they were automatically enrolled on the training for the following year.

Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical safety checklist is a tool to improve the safety of surgery by reducing deaths and complications. We saw that those women who had undergone surgery had completed WHO checklists within the records. However, out of four WHO surgical checklists seen, one had not been fully completed.
- We saw a WHO surgical checklist audit completed in October 2015. The trust target was for 85% in all domains. This was achieved in one domain. Results were particularly low in three sections: team brief/ handover was 46%, sign out was 48% and team debrief was 48%. Recommendations from the audit included the introduction of an updated WHO checklist and re audit after the introduction; this was scheduled for November 2016.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings.
- Within maternity services staff used the modified early obstetric warning score (MEOWS). This enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- We reviewed eight sets of records and all had MEOWS scores calculated. We saw a MEOWS audit completed in June 2016, which showed 96% of charts, had been completed fully and accurately.
- The labour ward had developed a sepsis box that contained all the necessary equipment for monitoring and treatment.
- Midwives completed risk assessments at booking including diabetes and venous thromboembolism assessments. These determined whether the pregnancy was high or low risk. Risk assessments were updated at each appointment.
- Staff in antenatal clinic told us that they had a consultant with a special interest in mental health, substance abuse and teenage pregnancies. Others saw those with raised BMI's and complex twin pregnancies.
- We saw in records that handovers between labour ward and the postnatal ward were based on the Situation, Background, Assessment and Recommendation (SBAR) technique. SBAR is a communication tool designed to support staff sharing clear, concise and focused information, promoting quality and patient safety.

Midwifery staffing

- Midwifery staffing levels were reviewed in 2013 using the Birthrate Plus® midwifery workforce-planning tool in accordance with the recommendations and procedures outlined in the NICE safe staffing guidelines. This assessment identified that 216 whole time equivalent (WTE) staff were required to provide safe care for mothers and families. A desktop exercise demonstrated that the funded establishment in May 2016 was 213.9 WTE staff.
- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) recommend a ratio of one midwife to 28 births (1:28). The trust as a whole had a ratio of 1:24. However, staff we spoke with said that although they had the correct ratio it did not feel like there was sufficient staff in practice. One member of staff we spoke with commented that there were the right numbers of staff but not necessarily in the right place.
- Midwives had to act in the scrub nurse role in the obstetric theatre, which put pressure on the labour ward staffing. RCOG standards (2007) state that the midwife has a continuing role in the care of the woman and newborn in the theatre environment but should not be undertaking the 'scrub' role and recommended that there should be a dedicated theatre team.
- We reviewed published staffing figures between February 2016 and April 2016. In February 2016, fill rates

were 95% for day shifts and 95% for night shifts. In March 2016, day shifts were 91% and night shifts 99%, and in April 2016, the fill rate was 97% for day shifts and 101% for night shifts.
- There was an escalation policy for staff to follow if staffing levels fell below agreed levels.
- We saw that staffing numbers were displayed on the wall outside the wards. At the time of our inspection, actual numbers met planned numbers.
- Data provided by the trust showed that for maternity services across the trust as a whole, women were not always receiving one to one care in established labour. Between August 2015 and August 2016, the figures ranged from 96% of women receiving one to one care in August 2015 to 90% in April 2016. The average over the year was 93%.
- The pregnancy assessment unit was staffed with one to two midwives during the day and one midwife at night.
- The labour ward co-ordinator was in a supernumerary role. However, if the ward was busy then they were needed to provide clinical care, but would not care for a woman in established labour.
- We saw two midwives working in the antenatal clinic at UHND. The trust told us these staff members cover antenatal clinics at both UHND and Shotley Bridge Hospital. The senior midwife managed both of these services. Staff could cover on ward 10 if needed but they did not cover the labour ward and did not have regular updates of practice.
- The head of midwifery told us the sickness absence rate had recently reduced from over 8% to 4.6%, which was in line with the trust target of 4.5%.

Medical staffing

- Medical staffing was similar to the England average with almost half of the staff being consultants and only 4% being junior doctors.
- There were 11.67 whole time equivalent (WTE) obstetrics and gynaecology consultants at the University Hospital of North Durham.
- The labour ward utilised a consultant of the week system to provide consultant presence 9.00am to 9.00pm Mon to Fri and 9.00am to 12.00pm at weekends.
- One of the consultants we spoke with told us the on call consultant covered the labour ward, acute gynaecology, antenatal and postnatal wards, and accident and emergency This meant that it could be challenging at times to meet all medical needs for the service.
- There was dedicated consultant anaesthetist cover for the labour ward between 8.00am and 6.00pm. Out of hours cover was provided by the on call anaesthetist for the hospital.

Are maternity and gynaecology services well-led?

- There was a newly formed senior leadership team in maternity. The team was cohesive and there was a real drive to improve the quality of the service. The team were aware of the challenges and were able to articulate the actions required to take the service forward.
- Plans were ongoing concerning the configuration of maternity services. Whilst the trust continued to develop an overall strategy and supporting plans, the final configuration of services within the trust, would be determined through the work on the Sustainability and Transformation Plans (STP) in the North and South of the North East health economy
- Governance structures were in place.
- Staff spoke positively about their leaders and felt respected. Plans were in place to strengthen clinical leadership.

Vision and strategy for this service

- Maternity services were part of the family health care group.
- The trust had a clinical services strategy 'Right First Time' 2013/2014. Whilst the Trust continued to develop this overall strategy and supporting plans, the final configuration of services within the trust, as part of the overall configuration of services within the North East health economy, would be determined through the work on the Sustainability and Transformation Plans (STP) in the North and South of the North East health economy. Managers recognised the long-term impact STPs could have on maternity services at both sites but were also clear about ensuring the efficiency and safety of the service in the immediate short-term.
- A work programme was in place and obstetrics and gynaecology had produced a plan in response to the new models of care.

Governance, risk management and quality measurement

- A Band 7 patient safety midwife was in post. However, only 22.5 hours a week were allocated to this role.
- The obstetrics/maternity risk register identified four risks related to the delay of implementation of the system for storage of ultrasound images, recommendations following an external review, gaps in middle grade rota, and sickness/absence levels. The Family Health Joint Clinical Quality and Patient Experience Steering Group reviewed the risk register each month.
- The service had a maternity dashboard, which reported performance data across both sites, and updated every month. The head of midwifery (HOM) was working in collaboration with regional HOMs and the deputy director of nursing to review regional clinical measures and other regional comparative data to assess how the service measured standards across the regional network.
- Monthly clinical governance meetings were held. These were cross-site meetings. Minutes reviewed showed that risk and performance were discussed as standing agenda items.
- Joint meetings with other services in the family health care group were held related to patient safety and clinical quality.
- Risk meetings were held weekly, led by a senior midwife. Midwives and medical staff attended them. Key messages were produced to disseminate to all staff. We saw these displayed on notice boards.
- Outcomes from the Governance Patient Safety and Quality committees fed into the relevant trust wide committees, which reported directly to the trust board. The clinical director and HOM saw all serious incidents and root cause analysis (RCA) investigations. Once completed, RCA's were signed off by the Obstetrics and Gynaecology Assurance Meeting before being presented at the Care Group Patient Safety meeting and Trust wide Patient Safety meeting.
- Supervisors of Midwives (SOM) were present at maternity risk management meetings, clinical governance meetings and root cause analysis reviews. Issues of risk and governance were discussed at their Supervisors meetings.
- Senior managers acknowledged that, over recent months, there had been a focus on responding to actions identified within the external reviews of the service rather than governance as a whole. Managers explained key service priorities now included strengthening those current governance arrangements with the involvement of all nursing and medical staff. The service had started a clinical governance review and proposed a future framework. This included a monthly full day governance meeting using the principles 'SAGE' (safeguarding, audit, governance and education).
- The service had an action plan in response to the Morecambe Bay Investigation recommendations. The majority of these were completed with a few still partially completed due to ongoing re-organisation of the trust.

Leadership of service

- There was a newly formed senior leadership team in maternity. We found that this team was cohesive and that there was a real drive to improve the quality of the service. The team were aware of the challenges and were able to articulate the actions required to take the service forward. The team said that they were supported by the Trust Board.
- The service was recruiting two strategic leads for obstetrics and gynaecology, and these new posts would provide the direction and leadership to drive and support the clinical strategy. The medical teams would also be supported operationally by a lead on each acute site. These would provide day-to-day management and leadership in both specialities including labour ward lead and risk leads. Job descriptions were completed and posts would be recruited to by September 2016.
- Staff spoke positively about the head of midwifery and matron.
- As part of the leadership plan, acute matrons would provide leadership across the whole acute site including providing a five day presence on the unit, and be visible at handover and safety huddles. The move to cover the whole service rather than the delivery suite as a priority would be supported by the introduction of delivery suite managers. Posts would be advertised in September 2016.
- An experienced Band 7 labour ward coordinator was in charge on every shift.
- All midwives had a Supervisor of Midwives (SOM) who supported their clinical practice. The ratio for Supervisors to midwives was 1:14, which met the national recommendations.

Culture within the service

Maternity and gynaecology

- All staff we spoke with said that they worked as a team. They felt respected and felt that they could approach any member of staff and could challenge if necessary.
- Staff told us there were no concerns around bullying or undermining behaviour, but they were encouraged to report any such incidents.
- Junior members of medical and midwifery staff felt well supported.

Public engagement

- Every family was given a Friends and Family Test (FTT) questionnaire to complete. Results for July 2016 showed that from 61 responses to the postnatal ward questionnaire, 84% of women would recommend the service to friends and family. The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Staff engagement

- Staff told us they were encouraged to put their ideas forward for service development.
- Staff took part in an annual staff survey. Results from 2015 showed that 69% felt they were able to contribute to improvements at work.

Innovation, improvement and sustainability

- The transitional care team had won the service improvement award in the annual staff awards and had been shortlisted for the Royal College of Midwives (RCM) annual midwifery awards 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that the recent improvements to the governance framework are fully embedded to support the delivery of high quality care, including assessment, approval and compliance of guidelines.
- Improve compliance against the WHO surgical safety checklist.

Action the hospital SHOULD take to improve

- Continue to implement the recommendations identified in the review of midwifery staffing to ensure the appropriate deployment of staff in the correct areas.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Ensure that the recent improvements to the governance framework are fully embedded to support the delivery of high quality care, including assessment, approval and compliance of guidelines. • Improve compliance against the WHO surgical safety checklist.