County Durham and Darlington NHS Foundation Trust

Darlington Memorial Hospital

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.

Our key findings were as follows:

- 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.
- Following work the trust had undertaken with the support of occupational psychologists and the more recent external reviews, there was some improvement in clinical behaviours but there continued to be issues relating to the cohesiveness of certain groups of medical staff. Certain elements of the obstetrics team remained dysfunctional with a lack of clinical engagement and support. The trust was continuing to work with the relevant members of staff and external partners to resolve current issues.
- 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.
- The antenatal clinic relied upon a paper-based logbook to record blood test results. This was a potential risk to patient confidentiality and loss of data.
- There was a lack of space for handover on the delivery suite to take place.
- 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 action continues to be taken to address poor behaviours and performance that is inconsistent with vision and values.
- 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.

Summary of findings

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.
- Review the process for recording of blood test results in the antenatal clinic.
- Improve the environment for handover on delivery suite to ensure it is fit for purpose.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Darlington Memorial Hospital

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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

Darlington Memorial Hospital and the University Hospital of North Durham provided maternity services for County Durham and Darlington NHS Foundation Trust. The maternity services offered at Darlington Memorial Hospital consisted of antenatal, intrapartum and postnatal services. The service delivered 2391 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, the antenatal and postnatal ward, and antenatal clinic. We spoke with 28 members of staff and six mothers/families. We reviewed five sets of records.

Summary of findings

Overall, maternity services at Darlington Memorial Hospital were safe and well led. Staff knew how to report incidents. We saw evidence from actions plans and root cause analysis that serious incidents were identified and investigated appropriately.

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.

However, there continued to be issues relating to the cohesiveness of certain groups of medical staff. We observed that certain elements of the obstetrics team remained dysfunctional without local consensus. Although there was no evidence to suggest that individual clinicians were not caring for women, clinical engagement and support was not effective across all members of the team. The trust had carried out internal and external investigations and was continuing to work with the relevant members of staff and external partners to resolve current concerns. There was some improvement; however, any significant shift in culture would take time to embed. The management team were aware of the challenges and were able to articulate the actions required to take the service forward.

In addition, 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 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.

However:

- The antenatal clinic relied upon a paper-based logbook to record blood test results. This was a potential risk to patient confidentiality and loss of data.
- 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. A review of incident reporting was ongoing.
- 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 a subsequent re audit, scheduled for November 2016.
- There was a lack of space for handover to take place. Options to improve the environment were being considered

Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using an electronic management reporting system. Medical and midwifery staff attended weekly risk meetings to discuss incidents.
- Staff we spoke with gave us examples of service development resulting from reported incidents. For example, one woman who required a Down's syndrome test and a glucose intolerance blood test was booked to have both done at the same appointment. However, the midwife missed the Down's test and now all tests were undertaken independently at the pregnancy assessment unit instead of jointly at the antenatal clinic.
- Some staff we spoke with felt the review of incidents and the sharing from lessons learned could be stronger. For example, staff described a lack of action plans and outcomes which meant lessons did not appear to be learned.
- There were no never events recorded between August 2015 and July 2016. Never events are incidents determined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- There were seven serious incidents reported between August 2015 and July 2016. We reviewed the root cause analysis (RCA) from one of the incidents, which included actions and lessons learned, and we noted staff had applied duty of candour.
- Medical and nursing staff attended weekly risk meetings to discuss incidents. The patient safety midwife disseminated learning from these meetings through a key messages notice that they emailed to staff and placed on notice boards. We saw these notices displayed during our inspection.
- Minutes from governance assurance and patient safety meetings showed that incident reporting was a standing agenda item.
- Staff attended morbidity and mortality meetings every two months. We saw minutes from these meetings. The meetings were attended by obstetric and paediatric 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.

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

- There were six antenatal beds and 11 delivery rooms on the labour ward, one of which had a birthing pool and one had en-suite bathroom facilities. The post-natal ward had 15 beds and managers told us they had reduced the number of beds in each bay from four to three, to provide more space and privacy for patients.
- We saw evidence of processes to ensure equipment was safe. We also saw documentation for checking and cleaning equipment.
- There was adequate equipment on the wards to provide safe care, including cardiotocography (CTG) machines, used for the monitoring of fetal wellbeing. Resuscitation trolleys were stocked appropriately and staff regularly checked them. Staff told us they had access to appropriate equipment when needed.
- Resuscitaires, used to support new-born babies who may need warming or resuscitation after delivery, were available in each delivery room. These were checked on a daily routine schedule, with records made to support this.
- There was one operating theatre with a two-bay recovery room immediately accessible on the labour ward. When this was in use, staff used the main theatres.
- Staff used the ward kitchen to convene due a lack of other suitable or available space. Senior nurses acknowledged this was not always convenient or practical and were considering other options.
- The antenatal clinic used a paper-based logbook for recording blood test results, which meant the information was not easily accessible or shared. There was also a risk to patient confidentiality.

Medicines

- Medicines were securely stored and handled safely. Most of the storage cupboards were tidy, well organised and locked. However, we did find the drug cupboard in theatres was unlocked. Staff we spoke with told us this was an unusual occurrence and took immediate steps to rectify the problem.
- We reviewed four prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented and medication that was omitted or not administered had a documented reason.

Records

- Medical and nursing staff managed and stored records safely. We did not see any unattended notes during our inspection.
- We reviewed five sets of care records. Overall, records were clear, accurate, and legible. Staff recorded appropriate information including VTE risk assessments, evidence of input from the multidisciplinary team and patient observations. All notes were signed and dated.
- 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. Staff did not report any problems accessing training or having the time to complete the relevant modules. Training was on a rolling programme so staff were automatically enrolled on the training for the following year.
- Information we received from the trust showed 81% of midwives and 56% of medical staff had attended obstetric emergency skills and drills training (as of September 2016). The training included cord prolapse, vaginal breech, shoulder dystocia, and eclampsia. We spoke with a supervisor of midwives who told us they tried to arrange drills as frequently as possible and liaised with other departments to ensure a maximum

learning experience, such as paediatrics and the cardiac arrest team. Student midwives we spoke with told us they had attended several drills and found the experience to be very positive.
- Staff had received training on the sepsis bundle and were aware of the sepsis policy.

Assessing and responding to patient risk

- We saw a World Health Organisation (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.
- A specific risk assessment was used in maternity, known as an early obstetric warning score (MEOWS). Escalation processes in response to MEOWS had been reviewed following an incident and the threshold for triggering an emergency response was lowered. Midwives said women with a score above5 triggered the use of a 'call out cascade' giving specific instructions regarding level of monitoring, referral for advice, review, and immediate actions to be considered.
- We reviewed five sets of records and all had MEOWS scores calculated. We saw a MEOWS audit completed in June 2016, which showed staff had completed 100% of charts fully and accurately.
- Midwifery staff and sonographers we spoke with did not report any problems escalating concerns about a woman or a baby to a consultant.
- Midwives completed risk assessments at booking including diabetes and venous thromboembolism assessments. These determined whether the pregnancy was high or low risk. Midwives updated patient risk assessments at each appointment.
- Midwives we spoke with told us 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). In 2015/16, the trust as a whole had a ratio of 1:24. This meant there was sufficient staffing. However, staff we spoke with said that although they had the correct ratio, it did not always feel like midwives were deployed appropriately between the labour and post-natal wards.
- In addition, 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 new-born in the theatre environment but should not be undertaking the 'scrub' role and recommended that there should be a dedicated theatre team.
- A number of actions were identified from the review of midwifery staffing in May 2016. These included a review of the current configuration of staff, a plan to take midwives out of the scrub role in obstetric theatre, review of roles and responsibilities, introduction of midwifery red flag events and introduction of a labour ward acuity tool. Minutes of the July 2016 Trust Board (Nurse Staffing Report: Midwifery Bi-Annual Review) showed that actions in response to recommendations, set out in section 8 of the report, were in hand.
- Daily handover meetings took place at 7.00am and 7.00pm with additional safety huddles throughout the day.
- There was an escalation policy for staff to follow if staffing levels fell below agreed levels.
- 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%.

- There were two dedicated patient safety midwives (one at each site), an infant feeding co-ordinator, a bereavement midwife, and a safeguarding midwife. The risk midwife had 22.5 hours allocated to patient safety and worked 15 hours on the labour ward, this was becoming difficult to sustain because of increases in the non-clinical work. A full time patient safety post was being considered.
- 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 across both sites was similar to the England average with almost half of the staff being consultants and 4% being junior doctors.
- There were 10 whole time equivalent (WTE) obstetrics and gynaecology consultants all of whom had labour ward duties, and with four covering resident night shifts.
- Consultant presence on the labour ward for the number of births in the unit was 98 hours. This was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) standards.
- There was consultant presence at weekends between 9.00am and 1.00pm, with an on-call service thereafter.
- There was no separate on call arrangement for obstetrics and gynaecology.

Are maternity and gynaecology services well-led?

- The trust had a clinical services strategy. Whilst the trust continued to develop this 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. This included maternity services.
- 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 HOM was supportive and approachable. Plans were in place to strengthen clinical leadership.

However:

- 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.
- Following work the trust had undertaken with the support of occupational psychologists and the more recent external reviews, there was some improvement in clinical behaviours but there continued to be issues relating to the cohesiveness of certain groups of medical staff. Certain elements of the obstetrics team remained dysfunctional with a lack of clinical engagement and support. The trust was continuing to work with the relevant members of staff and external partners to resolve current issues.

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

Maternity and gynaecology

- 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 the 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.
- 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 Group before being presented at the Care Group patient safety meeting and trust wide patient safety meeting
- Some staff we spoke with told us they felt the governance structure was not as robust as it could be. For example, staff described a lack of action plans and outcomes from incidents did not always identify lessons learned. We spoke with one specialist midwife who chaired a weekly meeting on the ward. She explained the outcomes from those meetings did not feed into any other meeting and lessons were not always shared.
- However, minutes of the Clinical Quality Review Group showed that learning was in place following a serious incident. Actions included implementing a pathway with South Tees, a daily 8.00am multi-disciplinary team huddle, daily safeguarding updates and weekly report updates. Plans to change consultant jobs plans were also underway.
- 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, midwifery 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).
- We observed the labour ward forum and risk meeting. It was not clear if the meetings were quorate or the assurance processes to ensure that actions were completed. There was no paediatric presence at the meeting; staff said that paediatric staff did attend if there were items relevant to their area. The service was in the process of reviewing its meeting structures and functions and revising terms of reference.
- Although clinical guidelines were reviewed and updated, assurance processes to ensure guidelines and practice was followed was not clear which led to confusion amongst staff and women. Staff told us the system to navigate to the correct guideline was also difficult. The assessment, compliance and approval of guidelines were included in the governance review.
- 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 the Trust Board supported them.
- 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.
- There was continued clinical and operational input from South Tees to support the service.
- Staff spoke positively about the head of midwifery and told us they had a visible presence on the unit.

- Midwives told us they felt supported by their immediate superiors, those who were band 7 and below. They felt they worked as a team but not every member of staff told us they felt valued by their manager.
- 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.

Culture within the service

- There continued to be issues relating to the cohesiveness of certain groups of medical staff. We observed that certain elements of the obstetrics team remained dysfunctional without local consensus. Although there was no evidence to suggest that individual clinicians were not caring for women, clinical engagement and support was not effective across all members of the team. The trust had carried out internal and external investigations and was continuing to work with the relevant members of staff and external partners to resolve current concerns. There was some improvement; however, any significant shift in culture would take time to embed.
- Midwifery staff said they had seen positive changes in behaviours since the external review amongst most of the medical staff. They felt that they had good working relationships and were able to call consultants at any time during the day or night.
- Junior doctors said they received good support from consultants and felt welcome on the unit. However, one doctor said they felt 'less protected' compared to other units.
- Staff said there was good communication from the head of midwifery (HOM) and ward managers and felt they were fully informed about what was happening in the service. For example, the HOM met with staff on the night shift to ensure that they received the same messages as day staff.

Public engagement

- Every family was given a Friends and Family Test (FTT) questionnaire to complete. Data for July 2016 showed 96% of women would recommend the service for birth, 100% for antenatal care and 74% for post-natal care.
- In the 2015, Maternity Survey the trust scored about the same compared to other trusts for labour and birth and care in hospital after the birth. It scored better than other trusts for staff during labour and birth.

Staff engagement

- Staff told us they were encouraged to put their ideas forward for service development. For example, changes had been made to discharge planning and improved escalation MEOWS charts.
- Staff took part in an annual staff survey. Results from 2015 showed that 69% felt they were able to contribute to improvements at work.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that senior management continue to take action to address poor behaviours and performance that is inconsistent with vision and values.
- 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.
- Review the process for recording of blood test results in the antenatal clinic.
- Improve the environment for handover on delivery suite to ensure it is fit for purpose.

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 senior management continue to take action to address poor behaviours and performance that is inconsistent with vision and values. • 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.