Review of compliance

Peterborough and Stamford Hospitals NHS Foundation Trust Peterborough City Hospital	
Region:	East
Location address:	PO Box 404 Bretton Gate Peterborough Cambridgeshire PE3 9GZ
Type of service:	Acute services with overnight beds Hospice services Long term conditions services Community healthcare service
Date of Publication:	October 2011
Overview of the service:	Peterborough and Stamford Hospitals NHS Foundation Trust provides a range of hospital-based acute healthcare services to people across Peterborough,

	North and East Cambridgeshire, South Lincolnshire, West Norfolk, East Northamptonshire, East Leicestershire and Rutland. Currently over 3000 staff provide services from sites in Peterborough and Stamford.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Peterborough City Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 31 August 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

All of the patients we spoke with during our visit to the Maternity Unit told us they had always been shown respect by the staff caring for them. Staff were polite, caring and attentive and they said that they were treated with respect and dignity. They also told us their partners and husbands were treated with respect and welcomed into the unit. One patient told us, "All the staff have been very nice, they're all helpful. They spend time explaining things".

The care provided was of a good standard and one woman said, "Staff have all been really nice, supportive and have had the time to talk". Most patients said they received care and treatment quickly and did not have to wait. They told us that there were usually enough staff and that they had received one to one care from a midwife while in labour.

What we found about the standards we reviewed and how well Peterborough City Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Improvements that have been made make sure patients using the Maternity Unit are able to make choices and decisions about their care. Staff treat them with respect and ensure their privacy and dignity is maintained, which means they are put at the centre of their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients in the Maternity Unit receive care, treatment and support that meets their needs. However, some aspects of the treatment provided is not always provided in a timely way.

Outcome 07: People should be protected from abuse and staff should respect their human rights

There are procedures in place with clear understanding by staff about what to do to ensure patients in the Maternity Unit are safeguarded from abuse.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider has ensured that there are enough staff available to make sure the safety and well being of patients using the Maternity Unit. However, to maintain compliance, action that has been planned to maintain recruitment should continue to ensure staffing levels are maintained.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Patient satisfaction and care in the Maternity Unit is monitored through clinical governance and survey systems, which ensures there is effective decision making and risk management of patient health, welfare and safety.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We completed a thematic report before carrying out the review of the maternity services at Peterborough City Hospital. This report took information from a national survey carried out in 2010 when services were delivered from another site, before the Maternity Unit's move to Peterborough City Hospital. The report showed that patients experienced similar care at this unit to other maternity units across the country. High percentages of women at this trust were given clear explanations and reasons for scans and screening tests; they could move around while in labour; they received the pain relief they wanted; they were involved in decisions and they had confidence in the staff and were made to feel welcome.

However, this also meant that approximately a quarter of women said they were not given a choice of where to have their baby and were not given the information or explanations they needed. Approximately one fifth of women who responded to the survey said that they felt they were not treated with kindness and understanding after the birth of their baby.

All of the patients we spoke with during our visit to the unit told us they had always been shown respect by the staff caring for them. Staff were polite, caring and attentive and the women's privacy and dignity was upheld and maintained at all times. They also

told us that their partners and husbands were treated with respect and welcomed into the unit. One patient told us, "All the staff have been very nice, they're all helpful. They spend time explaining things". Another patient told us that their experience had been positive and their partner reflected this by saying he felt the well-being of his partner was looked after and he had felt involved and not in the way.

Other evidence
We spoke with staff members in different parts of the unit who were caring for patients before, during and after the birth of their babies. Staff were able to explain to us about the philosophy of the unit and how they aim to make sure that the patient is at the centre of care that is given. The hospital used a language line for patients whose first language is not English, although there are other ways of communicating with people used, which includes prompt sheets and information written in other languages.

During the site visit we observed how staff members interacted with patients and their relatives and visitors. Staff were polite when speaking with the patients; they knocked on doors before entering rooms most of the time and announced themselves before going through privacy curtains that surrounded the beds. All staff told patients what they were there to do and asked if this was acceptable before beginning the task.

We were provided with an action plan by the trust, which showed how they were addressing lower satisfaction rates identified in the 2010 national survey. Some of these actions looked at the low participation in antenatal classes in the area and how this may be improved. One patient confirmed to us she was able to attend antenatal classes close to her home and the trust had set up men only antenatal classes, to provide information in a way that supported husbands and male partners.

Our judgement
Improvements that have been made make sure patients using the Maternity Unit are able to make choices and decisions about their care. Staff treat them with respect and ensure their privacy and dignity is maintained, which means they are put at the centre of their care.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Comments about the care received while in the hospital Maternity Unit were generally positive from the patients we spoke with. One woman said, "Staff have all been really nice, supportive and have had the time to talk".

Two women told us they had needed minor medical attention following the birth of their babies and that this had been completed quickly within 10 to15 minutes after the birth. Most of the patients said they had adequate pain relief during their labour; two women confirmed this was the pain relief of their choice and that staff had taken appropriate action to relieve their distress. However, one women told us she had to wait for five hours for pain relief (this is discussed in more detail below).

Other evidence
Our thematic report showed that patients experienced care that was similar or better than expected when compared to other maternity units. However, this meant that just under two thirds of women were given consistent breast feeding advice, support and encouragement. A similar number (just under two thirds) of women who needed minor medical attention following the birth of their child received this within an hour of delivery.

The trust produced an action plan addressing these issues, which included providing more trained supporters of breast feeding in the unit and looked at reducing the severity of damage that women may experience during delivery and how often this occurs. Two women we spoke with told us they had been referred to the breast feeding specialist nurse to assist with difficulties they had been experiencing and this had helped them.

A report detailing statistical information about the unit was provided during the review. This showed that the number of patients who received treatment to repair damage within an hour of delivery was only 20%, or one fifth of those needing them. We have asked the trust to explain why this is the case and how they plan to increase the number of women who receive stitches within an hour.

One woman told us she had to wait five hours before receiving an intravenous infusion for pain relief. We asked the trust to look into this and they found that the infusion was for another medication to progress labour, but that there had been a wait of five hours before the infusion was started. The trust told us they had started to change the medication used to induce labour, this would reduce the need for additional intravenous medication and reduce the delay in the progressing women's labour.

Our judgement
Patients in the Maternity Unit receive care, treatment and support that meets their needs. However, some aspects of the treatment provided is not always provided in a timely way.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
All of the patients we spoke with in the Maternity Unit said they felt able to speak with any staff member if they were not happy with anything.

Other evidence
The trust had a designated safeguarding team of midwives who specialised in particular areas where women are vulnerable. The team worked with other health care teams, such as mental health services, and agencies, such as domestic violence units, to safeguard women.

We spoke to staff members in different areas of the unit about protecting women. All of them were knowledgeable about safeguarding procedures. They told us about the team, their work and how they would contact them.

Our judgement
There are procedures in place with clear understanding by staff about what to do to ensure patients in the Maternity Unit are safeguarded from abuse.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
There were generally positive experiences of staffing levels during people's stay in the Maternity Unit. Patients told us there were always staff members available, bells were answered quickly and staff were able to help. They also told us they had received one to one care from a midwife while in labour.

One woman told us she had to wait for several hours before there were enough staff to provide monitoring for her have an intravenous line started.

Other evidence
Our thematic report showed that generally the trusts staffing levels were similar when compared to other maternity units across the country. However, the birth to midwife ration was slightly worse than other units. This was a reflection of the condition that was imposed on the trust when they registered with us and their birth to midwife ratio was one midwife to every 43 births. The trust increased the number of midwives it employed and the condition was removed in late 2010.

We spoke with senior staff at the trust and were told that midwife vacancies had increased slightly following the recruitment drive last year. The ratio of midwives to births had been one to 35 births and at the time of our visit on 31 August 2011 was one midwife to 34 births. The trust had taken action to improve this ratio by identifying reasons why midwives had left and other reasons for a reduction in midwife numbers (such as maternity or long term sick leave). They had developed a system to predict the number of births expected in any one month and limited staff leave or arranged

additional cover. A business case had been completed for further midwives and another recruitment drive was planned.

At the time of our visit three delivery rooms had been closed to make sure the standard of care provided was maintained. All three shifts over each twenty-four hour period were covered with eight midwives each shift to cover the remaining available 11 rooms. There had been two closures of the unit since maternity services have been provided at Peterborough City Hospital. We were told this was due to capacity rather than low staffing levels. We looked at the records for one of these incidents and found this was the case: clear procedures were followed while the delivery unit was closed and the records showed alternative arrangements were made for those women who would have otherwise attended the hospital.

We spoke to staff members who told us they are usually busy. One staff member described that, although their work was completed each shift, they said that they didn't feel as if they had provided a good quality service and that they could have spent more time with patients. Another staff member told us about the effect a busy delivery unit had on other areas of the maternity unit. Staff were relocated from other areas, which meant that patients were not always able to obtain help and advice before coming to the unit. This in turn increased the workload of the unit as a whole.

Information received during our site visit showed that almost all (94%) of women received one to one care from a midwife while in labour. This was confirmed by patients we spoke with, although, as indicated earlier in this report, there was one incident where staffing numbers did not allow treatment to be given in a timely way. The trust told us they had started to change the medication used to induce labour, this would reduce the need for additional intravenous medication and reduce the delay in the progressing women's labour. The information also showed that there has been a slight increase, month on month, of staffing incidents since April 2011.

Our judgement
The provider has ensured that there are enough staff available to make sure the safety and well being of patients using the Maternity Unit. However, to maintain compliance, action that has been planned to maintain recruitment should continue to ensure staffing levels are maintained.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Most patients we spoke with said they had not been asked to give feedback about their care and treatment in the Maternity Unit; however one woman told us they were aware of the feedback survey form, but had not completed it.

Other evidence
We spoke to staff about how they obtained feedback about the care patients experience in the maternity unit. They confirmed that a survey is included in a pack given to all women in the delivery unit. Staff working in the transitional care unit confirmed that they reminded patients that the survey was in the pack before they were discharged. Patients were also asked to complete a set of short questions electronically before they go home.

Senior staff at the trust confirmed that the electronic questionnaire results were available on a weekly basis. The results were generally looked at each month as this gave a clearer indication of trends. We looked at results for the antenatal clinic for May and July 2011 and compared them with results from December 2009. They showed that patient satisfaction was generally very high and there had been a slight improvement between May and July 2011. There had been a significant improvement in patient satisfaction between December 2009 and the results from this year.

We were provided with the minutes of a clinical governance meeting from July 2011, which showed that patient and workforce focus group reports are also looked at as part of the meeting. Actions were identified for most of the items discussed and a tracker

system was in place to make sure these are followed up at further meetings.

Our judgement
Patient satisfaction and care in the Maternity Unit is monitored through clinical governance and survey systems, which ensures there is effective decision making and risk management of patient health, welfare and safety.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Maternity and midwifery services	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Treatment is not always provided in a timely way, which means that patients have to wait longer than is necessary.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Treatment is not always provided in a timely way, which means that patients have to wait longer than is necessary.	
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: Action should continue to be taken to ensure staffing levels in the maternity unit are maintained or increased.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: Action should continue to be taken to ensure staffing levels in the maternity unit are maintained or increased.	

Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: Action should continue to be taken to ensure staffing levels in the maternity unit are maintained or increased.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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