Review of compliance

Cambridge University Hospitals NHS Foundation Trust Addenbrookes and the Rosie Hospitals	
Region:	East
Location address:	Addenbrooke's Hospital Hills Road Cambridge Cambridgeshire CB2 0QQ
Type of service:	Acute services with overnight beds Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Diagnostic and/or screening service
Date of Publication:	December 2011
Overview of the service:	Addenbrooke's and the Rosie Maternity Hospital is a large teaching hospital with many specialist departments and over 1000 beds. It is the main location for

	Cambridge University Hospitals NHS Foundation Trust.

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

Our current overall judgement

Addenbrookes and the Rosie Hospitals 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We spoke with several women and their partner's about their experiences of the care and support received at the Rosie Maternity Hospital. Overall people were complimentary about the service, they advised that they had received relevant and timely information and felt well supported by staff.

However, one woman was not happy about the care and support she received during treatment after labour and another person advised that staffing levels, "Varied from shift to shift."

What we found about the standards we reviewed and how well Addenbrookes and the Rosie Hospitals was meeting them

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

Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.

Outcome 13: There should be enough members of staff to keep people safe and

meet their health and welfare needs

The trust has enough staff to ensure the safety and welfare of women using the maternity service. However staff do not always feel able to meet the needs of mothers and babies when staffing levels are low. To maintain compliance, action must be taken to secure consistent staffing levels.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff at the maternity unit are well supported and have good access to training. However the trust must ensure that all staff are supported to complete mandatory e-learning update training.

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

Feedback and quality monitoring information is reviewed by the trust to ensure the safety and welfare of women is maintained. However to maintain compliance the trust must continue to monitor incidents and the quality monitoring records of one to one care for women in established labour so that identified risks are appropriately managed.

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. When we propose to take enforcement action, our decision 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 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
We spoke with several women and their partners about their experiences of the care and support received at the Rosie Maternity Hospital. Overall people were complimentary about the service, they advised that they had received relevant and timely information and felt well supported by staff.

However, one woman was not happy about the care and support she received during treatment after labour and another person advised that staffing levels, "Varied from shift to shift."

Other evidence
Information we had collected prior to the review showed the trust has higher then average rates of caesarean section births. The trust advised us of action they have taken to try and reduce this including the introduction of a clinic to help support women who have had previous caesarean births to try for a normal delivery. The trust advised that they plan to review the impact of the work undertaken in the clinic in the near future. At the time of this review the numbers of caesarean section births remain at a higher than average level.

The trust advised that they also monitor the incidence of 3rd and 4th degree tears experienced by women during labour. The information is used to consider any areas of practice that could be improved to reduce the risk of occurrence for other women. They provided evidence to indicate that the incidence rates at the hospital compares with the national average.

The midwives who were working on Lady Mary Ward told us that they are able to meet the clinical needs of women. However, they felt the emotional and psychological needs of women are not always met, when other factors such as complexities of the births, ethnicity or socio economic factors influence care needs.

Our judgement
Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Most of the women that we spoke with during our visit to the maternity unit felt that staffing levels were adequate. One person who had been an inpatient for longer than most commented that staffing levels, "Varied from shift to shift".

Other evidence
The hospital has a current ratio of one midwife to every 35 births which is a lower rate than in the previous two years. The trust have since informed us that the ratio is one midwife to every 33.6 births when they also account for bank staff. Senior staff told us that the birth rate remains static and we saw evidence that the monthly birth rates are monitored. Information we collected prior to the review about the number of midwifery posts that have been vacant for more then three months indicated this was worse than the national average. We were provided with vacancy numbers and this showed that approximately 2.5 full-time posts had remained vacant for more then three months. Senior staff told us that the retention of staff on the maternity unit was generally good but due to financial constraints within the trust they were unable to recruit into some vacant posts. In addition we were advised that the trust have a number of part-time staff in the maternity unit who choose to work extra shifts; this means that the hospital do not need to use agency staff who are less familiar with the hospital.

All of the midwives that we spoke with felt the clinical needs of women were being met but they often felt unable to meet the psychological and emotional needs of women when they were short of staff. The care assistants that we spoke with told us they did not always have enough staff to meet the needs of mothers and their babies in a timely

way.

On the day of our visit, staff on the antenatal ward were coping with one less midwife on duty as a vacant shift had not been filled. All of the women that we spoke with felt that their needs were being met although during the afternoon, we saw two women ask for medicines that they had expected to receive earlier in the day.

Our judgement
The trust has enough staff to ensure the safety and welfare of women using the maternity service. However staff do not always feel able to meet the needs of mothers and babies when staffing levels are low. To maintain compliance, action must be taken to secure consistent staffing levels.

Outcome 14:
Supporting staff

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 competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Overall women that we spoke with told us they had received a good level of information, care and support at the midwifery unit.

Other evidence
We spoke with some midwives during our visit who told us that they have an annual supervision session and access to their supervisor whenever they need additional support. There is one supervisor for every 15 midwives. They also told us that there are regular training exercises to enable staff to recognise and deal with medical emergencies which may arise.

We also spoke with health care assistants and midwifery care assistants who said they felt well supported by midwives and they had good access to training. However, they also told us they struggled to complete the e-learning annual update training as they were not given protected time away from the wards to complete it.

All trainee midwives are supervised by a registered midwife and women's consent is requested for a trainee midwife to be present. The trainees that we spoke with felt well supported.

Midwives knew their rotational placements for the year ahead and alternated from working in prenatal to post-natal care which enabled them to see the whole spectrum of childbirth.

Our judgement

Staff at the maternity unit are well supported and have good access to training. However the trust must ensure that all staff are supported to complete mandatory e-learning update training.

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
The trust supplied us with information they had used from inpatient surveys to improve the maternity service. At the beginning of 2011, the information shows that the overall satisfaction levels fell below acceptable levels in one area of the maternity unit. The trust took action and women are now more satisfied with the service indicating that the planned improvements have been effective.

Other evidence
We spoke with staff on the maternity unit about the NHS staff survey results for the trust in 2010, where the overall result had reported a rise in near misses, and incidents. They told us that they report errors through an electronic reporting system, but were not aware that incident reports had increased. Several staff could describe the process for investigating moderate and serious issues and gave examples where practice had been changed to minimise risk. In respect of this the management of the maternity unit provided us with the last three quarterly monitoring reports; the most recent report for maternity services, covering April to June 2011, indicated that there has been an increase in reported incidents in this service in the last 12 months, however the number of serious issues reported has remained stable. The trust had investigated all serious issues and had acted upon their findings and taken relevant action as needed to improve practice.

Quality monitoring information supplied by the trust showed that the records of one to one care for women in established labour were poor, which we were advised was partly due to changes in the recording system. The trust advised that they planned to review

three full months of data in November 2011.

Staff told us that they are kept informed of best practice and policy changes through regular emails, monthly team meetings and weekly ward meetings. We saw evidence that this is in place.

Our judgement
Feedback and quality monitoring information is reviewed by the trust to ensure the safety and welfare of women is maintained. However to maintain compliance the trust must continue to monitor incidents and the quality monitoring records of one to one care for women in established labour so that identified risks are appropriately managed.

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
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.	
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: Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.	
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services

	Why we have concerns: Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.	
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: Overall, the care needs of women on the maternity unit are being met. However the trust should continue with their actions to reduce the rate of caesarean section births which remain higher than the national average.	
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: The trust has enough staff to ensure the safety and welfare of women using the maternity service. However staff do not always feel able to meet the needs of mothers and babies when staffing levels are low. To maintain compliance, action must be taken to secure consistent staffing levels.	
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Accommodation for persons who require treatment for substance misuse	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Feedback and quality monitoring information is reviewed by the trust to ensure the safety and welfare of women is maintained. However to maintain compliance the trust must continue to monitor incidents and the quality monitoring records of one to one care for women in established labour so that identified risks are appropriately managed.	
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	Activities) Regulations 2010	service provision
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	for women in established labour so that identified risks are appropriately managed.

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 to us within 28 days of the date that the final review of compliance report is sent to them.

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

Document purpose	Review of compliance report
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