CASE STUDY 1

Performance Issues in the area of quality

MATERNITY DEEP DIVE

1. BRIEF DESCRIPTION OF ISSUE

1.1 In 2010/11 The Trust was alerted to an increase in the reporting of Serious Incidents in the maternity Unit. While the threshold for reporting serious incidents in maternity units had been revised in NHS London there was a concern that serious incidents in the Whittington Hospital had increased more significantly than other Trusts.

1.2 It was not possible to determine if this was as a result of the introduction of the electronic incident reporting system Datix along with an increased awareness of incident reporting. At the same time the number of complaints about maternity services at the Whittington Hospital also appeared to increase with an increasing complexity of complaints being reported and the majority of complaints referring to unsatisfactory behaviour and attitude of staff. These combined with an increasing birth rate and acknowledgement of a facility in need of expansion and refurbishment led the Trust Board to request an in depth report on maternity services quality and governance issues.

2. BOARD'S UNDERSTANSING OF THE ISSUE AND HOW IT ARRIVED AT THIS

2.1 Reports to the Trust Board in 2010/11 identified a rise in the number of complaints from 37 in 2009/10 to 53 in 2010/11. The types of issues being highlighted in complaints were attitude of staff and communication along with issues related to quality of treatment and care and issues associated with the poor state of the maternity building. There was an increase in serious incidents from 0.3 per 100 births in 2009/10 to 0.9 per 1000 births in 2010/11. The Trust moved from a position of being the lowest reporter of Sis in 2009/10 to the highest in 2010/11. The Trust also moved from a position of holding level 2 CNST assessment in 2009 to level 1 in 2011 and while it was explained that this was the result of changing standards in year there was a concern that reputationally this would have an impact on the Trust and at the same time there was not a clear acceptance that the Trust could not have met the level 2 standard.

3. THE CHALLENGE / SCRUTINY PROCESS INVLOVED

3.1 The Board requested the Women Childrens' and Families Division to present a deep dive of quality and patient safety issues to the Board in June 2011.

3.2 This presentation included an overview of maternity services, review of all complaints about maternity services identifying key themes and trends and an analysis of all serious incidents from April 2010 – June 2011. The analysis of Serious Incidents did not identify any themes or trends in the cause of the incidents and it was concluded through the review that the Trust had succeeded

in encouraging staff to be more open about reporting incidents within the criteria laid down by NHS London. It further concluded that the majority of SIs (84%) were unavoidable and those that were deemed avoidable did not highlight any particular area of recurring concern. NHS London and CQC both verbally acknowledged that they did not consider the Whittington Hospital to be an outlier in this area. However NHS London did comment that the quality of Investigation and Root Cause Analysis needed to improve.

3.3 A mock unannounced CQC visit was conducted by staff external to the Maternity Unit, the outcome of which was presented as part of the Deep Dive. The issues raised in this report were related to poor record keeping, quality of information provided to women, staff attitude and policy review.

4. HOW THE ISSUE WAS RESOLVED

4.1 The Board with the senior team from the Women's', Children's' and Families Division discussed all of the above. A number of presentations of the outcomes of the reviews mentioned above were made with in-depth discussion and challenge from Board members to the Divisional team. The Board then directed the division to develop a business case for an expanded maternity unit and to consider capping the number of births accepted by the unit. It was also agreed that the division should develop a policy with clear criteria to guide staff to consider when closure of the unit on the grounds of safety should be considered and actioned

5. KEY LEARNING POINTS

5.1 The key learning points from this exercise were:

- The maternity unit is under pressure with a growing birth rate
- The current facility is no longer fit for purpose
- The service is safe
- There is an increasing openness in terms of reporting incidents and conducting investigations
- Action needs to be taken to improve the attitude and communication of staff in the unit
- Decisions should be made in the Trust whether or not to cap the number of births accepted and this should be agreed with Commissioners
- A business case for refurbishment/expansion of the unit should be developed and presented to Commissioners

6. KEY IMPROVEMENTS MADE TO THE TRUST'S GOVERNANCE ARRANGEMENTS DIRECTLY AS A RESULT OF THE ABOVE

6.1 The key improvements from this exercise were:

- Greater understanding of the issues in the Maternity Unit
- There is clarity of direction from the Trust Board regarding the decisions to be made in relation to the maternity Unit

- There is improved reporting and quality of investigation SIs which are now signed off by the Divisional Board before being presented to the Executive SI review panel
- There is improved response both in time and quality to complaints and appropriate actions are being taken
- Complaints are signed off by the Divisional Director of Operations and are discussed at the Divisional Board
- The Divisional Board reports on quality safety and patient experience issues twice yearly to the Quality Committee a sub committee of the Trust Board.