Review of compliance

University Hospitals of Morecambe Bay NHS Foundation Trust

Region: North West

Location address: Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG

Type of service: Acute service

Publication date: September 2011

Overview of the service: The Trust operates from three main hospital sites: Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital.

Each hospital has a range of 'General Hospital' services, with full Accident & Emergency Departments, Critical/Coronary Care units, maternity services and Consultant led beds at both Barrow and Lancaster.

All three sites provide a range of planned care,
including outpatients, diagnostics, therapies, and day-case and inpatient surgery. In addition a range of local outreach services and diagnostics are provided from a number of community facilities.
What we found overall

We found that University Hospitals of Morecambe Bay NHS Foundation Trust was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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

Why we carried out this review

We carried out a responsive review against the regulated activity for Maternity and Midwifery Services. Maternity care is provided at three hospital locations of the University Hospital of Morecambe Bay Foundation Trust (the trust).

This review was initiated in response to several concerns that were brought to the attention of Care Quality Commission in relation to the provision of maternity care at the trust. These concerns included the findings of the Coroner Ian Smith's inquest and the subsequent rule 43 letter issued to the trust in June 2011.

A rule 43 letter is sent to an organisation by the coroner when they believe action should be taken to prevent any further deaths. Although the inquest case was in relation to a death in 2008 the coroner believed that some aspects of the care failures in the case may still have some relevance to improve the trust working practices today. The areas highlighted in this letter included; records management, team working, and the pressure of work and continuity of care.

The trust commissioned a review of its clinical governance arrangements, including all serious untoward incidences that occurred in maternity services in 2008. This review was undertaken by three external maternity professional experts and was called the Fielding Review (finalised August 2010). The review identified many areas for improvement and change along with issues relating to the ‘culture of team working’.
We conducted our site inspection unannounced and this was undertaken jointly with the Nursing and Midwifery Council (NMC). The NMC have completed a separate investigation into the provision of supervision arrangements for midwives at the trust.

We carried out this review because concerns were identified in relation to the regulated activity Maternity and Midwifery Service and we have included the following outcomes:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Cleanliness and infection control
- Safety and suitability of premises
- People should be safe from harm from unsafe or unsuitable equipment.
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

How we carried out this review
We reviewed all the information we hold about this provider, we spoke extensively to other agencies including the North West Strategic Health Authority (SHA), commissioners of maternity services and their medical leads.

We carried out site inspections of maternity services across three hospitals commencing with Furness General Hospital on 18th July, the Helme Chase unit at Westmorland General Hospital 19th July and Royal Lancaster Infirmary 20th July 2011.

During our site inspections we observed how mothers and babies were being cared for, talked with them and their partners and relatives, talked with midwives, medical staff and other supporting teams, checked the provider’s records, and looked at records of people who use services.

What people told us
We focused during our visits upon the experiences of the women using the maternity services across the Trust and on getting their opinions on the care and support they had received. We talked with mothers, their relatives, clinicians and midwifery practitioners and people expressed a range of largely positive views. Mothers we talked with confirmed that there were good levels of information provision across all three maternity units with mothers being given choice about the kind of care available to them.

The mothers we talked to told us that they understood their care and treatment and told us they were kept up to date about what was happening and given explanations about what was happening during their pregnancies and also during labour so they could make informed decisions. All the mothers we talked with expressed satisfaction
with the care and support they had received from the midwives during their stay on the maternity units. All those mothers we talked to on the post natal wards told us the midwives had “always” asked them what they wanted during their labour and given them explanations. All those we talked to confirmed that once in established labour they had not been left on their own by midwives. We were also told that doctors and consultants spent time with them and explained why changes to their plan were needed.

One mother told us staff had been “brilliant” and had “acted quickly when things changed” and that “all the options were discussed with us”. Another commented on the fact that they had felt able to ask their consultant questions “all the way through being pregnant”.

Another mum who had been transferred between units told us “It was a very quick response, and they (staff) explained as much as they could”.

Mothers also commented that they could see staff were busy at times during their stays and one in Furness General Hospital told us “They were very busy when I came in, despite that they were always there for me”.

What we found about the standards we reviewed and how well University Hospitals of Morecambe Bay NHS Foundation Trust was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found that there were good levels of information provision across all three maternity units with mothers being given choice about the kind of care available to them. We found some good practice in seeking people’s views, promoting privacy and providing information about services and what to expect.

Current practices at Furness General site in relation to the transfer of women to theatre for emergency obstetric procedures do not ensure their privacy, dignity and safety. Information is not being given to women regarding the facilities in use should they need an emergency transfer to the theatre suite so they could not make an informed choice or provide their views on these arrangements.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights.

There are inconsistencies with the standards of support for mothers and families across all the three sites. However, overall, women using the maternity services did receive appropriate care and their needs and preferences were being assessed with them and planned for with them. Record keeping was of a good standard of detail.
Outcome 6: People should get safe and coordinated care when they move between different services.

People who were using the maternity services were getting support to enable them to receive the services they needed from other health and social care providers in a coordinated way. The level of engagement and internal communication within the three sites around the handover of care of mothers and babies is effective.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

Whilst the overall level of cleanliness across all the three sites was of a good standard at Furness General Hospital an open area of the labour ward had not being identified as in need of cleaning. Some midwifery staff were not following the correct procedures for single person use items and this could place people at risk.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare.

The people using the labour ward at the Furness General Hospital site are inconvenienced and may be disadvantaged because of an outdated care environment and poor arrangements for people to access facilities. People may feel exposed and restricted as the environment does not offer modern facilities to support the more complex needs of families who may need privacy. It does not meet staff needs for a suitable work environment or fully meet the needs of people with disabilities.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment.

From what we saw at the three locations appropriate equipment to meet people’s needs was being provided and maintained and staff were being trained in its use.

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

Our observations, speaking to staff and reference to the risk registers for the operating theatres clearly indicated that there were problems associated with having only one emergency team available out of hours and at weekends. Staffing in theatres was not adequate to cover out of hours. Whilst people may not as yet have come to harm in such situations they were being put at risk and may have received a substandard level of care due to insufficient numbers of staff in the theatres. They may also have experienced delays in receiving the care they needed.
Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills.

We found that people using the maternity services were being supported by staff who had received appropriate training, appraisal and supervision. They were being supported to maintain and develop their skills relevant to the work they were undertaking.

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

The maternity and midwifery services have systems in place to evaluate and monitor care delivery and practice. Actions arising from the monitoring do not always take place in a timely manner. There are risk registers in place, however, these are not consistently applying a rating nor are concerns escalated to the most appropriate management level. There are gaps preventing escalation of concerns and staff are not always reporting near miss events. The trust is therefore reacting to events rather than promoting a preventative/proactive culture.

We found that the medical team do not always work effectively within the clinical governance and leadership arrangements across all three sites. This means that some times clinical leadership and integrated working does not always achieve consistent approaches, for example medical staff are not always developing and delivering evidence based guidelines consistently across all three hospitals.

Relationships between some senior medical staff in certain areas did not demonstrate a joined up approach to working together. The impact of this was found to be negligible on patient care however long term inconsistencies and divisions may increase the risk of a two tier service which will not meet nationally recognised care pathways.

Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential.

Whilst there was evidence amongst midwifery and medical staff of some good practice in completing and keeping records of patient care we saw that the approach taken to storing and managing some medical records was not robust. Some records were not always being stored securely and managed in people’s best interests. The trust has not considered its practices and its responsibilities in relation to the current legislation protecting confidential information and also the codes of practice in relation to records management and information governance. This breach of data protection indicated to us a lack of rigor, oversight and accountability within the trust in this respect.

Action we have asked the service to take

We have asked the provider to send us a report within 14 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 review reports for more information.
At the last compliance review and visit to the Royal Lancaster Infirmary location on 20 April 2011 we found that there were also concerns around staffing arrangements within the orthopaedic wards we visited and compliance actions were made. All staffing issues at this location will be reviewed as part of following up the improvements that were needed at the previous inspection at Royal Lancaster Infirmary.

Whilst undertaking our review and inspection we found that the trust has not been registered in respect of the regulated activity ‘Diagnostic and screening procedures’. They need to do this by applying to CQC for a variation to their registration.
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 1:
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

There are moderate concerns with outcome 1: Respecting and involving people who use services.

Our findings

What people who use the service experienced and told us

All the mothers we spoke with at Furness General Hospital expressed satisfaction with the care and support they had received during their stay on the maternity unit. The mothers on the post natal ward we talked with told us they had “always” been asked what they wanted during their labour and given explanations by staff and that once in established labour they had not been left alone. One mother told us, “It was a very quick response, and they (staff) explained as much as they could”. They also told us that the consultant had spoken with them to explain why certain things had happened and why plans had to be changed. Another mother told us staff had been “brilliant” and had “acted quickly when things changed” and that “all the options were discussed with us”. Another commented on the fact that they had felt able to ask their consultant questions “all the way through being pregnant”.

One mother told us that staff had spent time with them telling them what help and support was available to them in the community when they went home. They also confirmed that staff had discussed pain relief issues and supported them whilst trying to breast feed.
Mothers we talked with also confirmed that they had been given information about what was available to them in their ante natal sessions.

At the Helme Chase maternity unit, in Westmorland General Hospital, mothers also expressed satisfaction with the care and support they had received during their stay on the midwife led unit.

One mother confirmed to us that they always felt they were informed about the care they needed and their consent was sought for examinations and interventions. They said that the doctors and midwives explained why treatment plans had to be changed and that their partners were also fully involved in decision making. They told us:

“They always answered my questions and told me what was happening”.

“Although I had some complications and had to be admitted early, staff always kept me fully informed of the care and treatments I needed”.

One mother told us, “Staff tried to keep to my birth plan but I had complications so this was not possible. They did transfer me to my unit of choice as soon as the baby and I were fit to travel’

Another told us, “I want to breast feed and staff are really supporting me in doing this’

A mother at Royal Lancaster Infirmary (RLI) maternity unit told us “I have no complaints or concerns about the way I was treated or with staff’.

Another told us, “This is my second baby so I know what to expect, however I was given loads of information when I had my first’.

Some of the mothers we talked with had been transferred to RLI from Helme Chase when ongoing risk assessments indicated that they required obstetric intervention. They were able to confirm to us that when risk had increased they had been informed of their options and action had been taken to transfer them. One told us “She (midwife) kept me informed and the theatre staff were very good, quick and it was well managed”.

Other evidence

Before our visits to the three maternity units we looked at all the information we held on maternity services in this Trust and we found that overall the majority of the feedback from the adult patient surveys was similar to other hospitals. Information from the Patient Environment Action Team indicated privacy, dignity and modesty for all three sites were better or much better than expected. We referred to the CQC maternity survey and this did not indicate any concerns regarding this outcome area. Many of the scores in this tended toward better than expected in comparison with other trusts.

The Care Quality Commission Maternity Thematic Report in June 2011 indicated that partners, relatives and those accompanying mothers in delivery were being made to feel welcome on units. This score was much better than expected.

We found that across the three sites mothers were being offered choice regarding the maternity care being offered across the trust. Some information about the three
sites and different services on offer is available on the Internet for women wanting to use maternity services in Morecambe Bay.

There is midwife led care at Helme Chase at the Westmorland General Hospital and home births are also available for healthy women who meet the criteria. The Community midwife is the lead professional, but if complications occur care can be transferred to a Consultant obstetrician for the appropriate care. Staff at Helme Chase told us that sometimes low risk patients have to be diverted to other units if they did not have the capacity to maintain a good and safe service in the unit. They told us that when women are first booked into antenatal care this is discussed with them so that they know and understand that this could happen. If such a situation occurred they may not be able to give birth to their babies on their first choice unit but would be admitted to another unit within the trust.

There is obstetric led care at Furness General Hospital and Royal Lancaster Infirmary which is well suited to women with pre existing medical conditions or previous complications in pregnancy and is open to any mother as her preferred choice. The consultant is the lead professional where this is the case. Mothers we talked with who were on this consultant led care pathway told us they had been able to meet with their consultant and members of the team providing their care throughout the pregnancy and ask questions as they needed.

We found on all 3 maternity units we visited that the records of care and what people wanted and preferred during and following birth were clearly recorded in the care plans. This included birth plans where mothers had chosen to do that, although one told us she had chosen not to have a birth plan and preferred to “go with events”.

The same system of recording ante natal, delivery and post natal information is in use across the trust for consistency. The plans contained management plans outlining the care that is agreed between mothers, midwives, clinicians and any specialists during different phases of their care. We saw that documentation through mother and baby’s journey from ante to post natal care included general and specific information on their needs and preferences and was within a continuous risk assessment framework.

The notes are presented as the property of the mother and they are developed in partnership with the midwifery practitioners caring for them. The notes also indicated for women a guide to their care options so mothers could make informed choices. We saw that assessments are undertaken for the mother throughout ante natal, during labour and following birth and that separate plans exist for baby. The assessments we looked at for the different stages of maternity care identified women’s additional and individual needs in a holistic way.

We observed that staff respected the privacy and dignity of people using this service wherever possible. Curtains around beds were closed appropriately for privacy and signs were in place reminding people to check with mothers before opening the curtains. Mothers we talked to felt that staff had done what they could to preserve their dignity, independence and privacy during and following delivery. One mother at Furness General told us that despite the birth not being as she had expected it had been “a good experience” with a lot of “one to one time from staff” and she was
pleased that she had been allowed to walk to the theatre, as she wanted to.

We found that appropriate consent had been obtained for surgical procedures and mothers confirmed that staff asked and made sure they explained why they were doing any examinations or monitoring.

We noted that whilst on the wards of all three locations mothers were having their privacy and dignity respected and promoted by the midwifery and medical staff caring for them. However we found that at Furness General Hospital should a mother need to be transferred quickly to the theatre because of an obstetric emergency this situation changed. There is no dedicated maternity theatre on the labour ward at Furness General Hospital so mothers needing emergency surgical procedures have to be transported along public corridors to the theatre suite. Whilst the distance may not take long to cover, during this time women may be in distress and the nature of the emergency may mean they will need intimate physical assistance by their midwife as they are transported. The support that may be needed for some obstetric emergencies would not be conducive to maintaining a person’s dignity or their privacy in a public place such as a hospital central thoroughfare.

We spoke with theatre staff who had experienced several obstetric emergencies with mothers coming to theatre on their bed, with a midwife on the bed maintaining pressure on the babies head. They described the experience as “very worrying” and had observed the lack of dignity for the mother.

We talked to midwives on the labour ward at Furness General Hospital about our concerns about the lack of dignity afforded to women whilst being moved to the theatre suite in an obstetric emergency. The midwives told us they had raised this concern themselves with senior management at different times. The midwives described for us the events when taking mothers to the emergency theatre. Staff stated that they would be on the bed under the covers applying pressure to the baby’s head.

We found that midwifery staff had developed their own informal systems for dealing with these emergency transfers over time to try to make the process as safe and effective as they could in the absence of any formal safety assessments and procedures. Staff told us the matter had been escalated many times so they knew the trust’s management were aware of the situation. As nothing had been done to change the situation staff confirmed to us they “just had to get on with it”.

We did not find any evidence that this less than satisfactory arrangement was subject to any monitoring by the trust to assess the risks in practice or monitoring to gain the views of mothers who had been through this. There was no evidence that mothers themselves had raised any complaints around this but equally there was no evidence either to indicate they had been asked about their experiences. We talked with mothers at Furness General Hospital who could not confirm that they were aware of the manner of this transfer should they need it. Nor was there any evidence from talking to mothers and looking at records that written or verbal information about this possibility, albeit unlikely, had been given. This did not
indicate to us that a woman centred perspective was being considered by the provider in these situations.

We did not find evidence of any safety risk assessments in place for mothers and midwives during emergency transfers and the midwives we talked with were not aware of there ever having been one. We did not see any evidence of contingency planning to mitigate the lack of privacy and dignity for mothers that could arise during an emergency obstetric transfer to theatre at Furness General Hospital. Nor could we see any formal procedures in place on how the staff were to manage any infant bereavement transfers from theatre back to the ward.

At the Royal Lancaster Hospital we saw that there is a dedicated obstetrics theatre off the labour ward so mothers can be quickly transferred should the need arise. This maintains their privacy and dignity within the unit and is also a quick and straightforward transfer should an emergency situation arise.

Our judgement
We found that there were good levels of information provision across all three maternity units with mothers being given choice about the kind of care available to them. We found some good practice in seeking people’s views, promoting privacy and providing information about services and what to expect. Current practices at Furness General site in relation to the transfer of women to theatre for emergency obstetric procedures do not ensure their privacy, dignity and safety. Information is not being given to women regarding the facilities in use should they need an emergency transfer to the theatre suite so they could not make an informed choice or provide their views on these arrangements.
Outcome 4:
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 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

The mothers we talked with during our visits were happy with the care, information and support they received during their stay on the maternity unit. One mother at Furness General Hospital told us;
“Although I did see different midwives during my prolonged labour I felt that they all were aware of the care I had received and needed and that I had a birth plan in place’.

Other women commented on the way they had been able to discuss the birth and ‘debrief’ when it had not gone as they had anticipated. One mother due for discharge following a caesarean section told us they had their discharge pack and that the consultant had been to talk to them about birth options for any future pregnancies.

At Helme Chase a mother told us, “I have always been able to access help and advice from my community midwife when I was at home’.

At the Royal Lancaster Infirmary we also received generally positive comments about people’s experiences and these included:
“Doctors do have a lot of time to speak to you”.

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“I think very highly of the Royal Lancaster Infirmary”.

“I came from Helme Chase ‘home from home’ room and I didn’t know what to expect here buts it’s been great, really kind and helpful staff.”

“I had my first child here so knew what to expect, I have received a fantastic service and have no complaints at all”.

“I know who the supervisors of midwives are because their photos are on the wall near the dining room, but I am unsure of their role and how it affects me.”

“Because I have complications I feel that the doctors are not sure what to do with me and that I am being passed from pillar to post; however the midwives have been brilliant”.

One mother felt some elements of their support were better than others and told us, “I had a bad experience with a male doctor; he was very matter of fact when he examined me and then tried the ‘comedy approach’. The midwives were more empathic and much more sensitive when they examined me”

Other evidence

Before our visits to the three maternity units we looked at all the information we held about this regulated activity within this Trust and spoke with other agencies, including commissioners of services in North Lancashire and Cumbria as part of our review. We undertook our visits and did this review jointly with the NMC Local Supervising Authority (LSA) review team.

We also referred to CQC maternity survey (June 2011) and overall the trust scored in the best performing, twenty percent, with positive feedback. The reports from mothers confirmed that services and care were able to meet their needs and we found examples where mothers had positive experiences during labour and expressed confidence in the team.

Across all the three maternity units and on labour and postnatal wards we found that staff were completing records of care, making individual observations, assessments of needs and risk and conversations and the rationale for decisions. These were accurate records as far as we could see from confirmation with mothers we spoke to. Our observations of care demonstrated that ongoing monitoring and a good level of advice and support was being provided to people using the service. Along with the NMC Midwifery Review Team, we examined detailed birth plans and delivery records.

We looked at several sets of care notes and records and those we saw were of a high standard and showed evidence of clear discussions with women about their choices for care. Staff we talked with confirmed that there were opportunities for mums to use the birthing pool if they chose to and if they met the criteria for safety. There was also some different positional equipment available to support mothers
during labour. There was good evidence in the case notes reviewed that mothers were involved and provided with choice and information about care options throughout their pregnancy and during the birth.

The records of care appropriately highlighted babies who required enhanced observation post delivery. Appropriate neonatal recordings were also being recorded.

The record keeping was being done to a high standard with emphasis on the individual mother and baby and the units had a named midwife system. We found that mother and baby’s notes stayed on the postnatal wards for up to a month after discharge. Notes can be updated by staff if necessary during this period. This means that the notes are easily available on the ward if there is any need for readmission or checking and reduces the risk of notes being mislaid in transit.

We saw that medical staff were keeping clear records and management plans and the written labour ward handover notes were available for inspection. Records were made four hourly and a ‘traffic light’ risk system used to monitor people and as an alert or indicator to seek assistance from medical staff. Midwifery staff we talked with at Furness General Hospital felt that this system was now “well embedded” and working well. We were told that doctors came to the labour ward every four hours to assess and discuss mother’s progress with their midwives and this enabled clear management plans to be formulated between all involved. Midwifery and medical audits of records were being done with one format across the trust to monitor record keeping. Using one format promotes a consistent approach across the trust.

At Furness General Hospital we saw good practice in having multi disciplinary meetings that have been set up for the review of all deliveries which entailed non planned caesarean sections. This meeting is weekly and is a forum in which consultants, doctors and midwives discuss the care of individual patients. One of the meetings was being held on the day of the visit to Furness General Hospital and we were able to attend and observe the proceedings. One of the aims of this meeting was to reflect on the care being provided and to learn from any adverse incidents, errors or near misses so that the risk of these incidents being repeated could be reduced to a minimum. During this meeting we observed a discussion between medical and midwifery staff regarding a ‘near miss’ incident. It became apparent that this incident had not been reported. We had to prompt the doctor to report this via the incident reporting system.

A consultant told us that there are systems in place to share learning. This is usually through various forums and doctors training sessions. Information is shared across the whole of the trust via the maternity risk management committee. We were told, and we could see ourselves, that the staff worked closely together on all the units we visited and all were approachable and open. It was also confirmed to us that following changes to the staffing of the theatre that there had been a much better response time in accessing theatres in an emergency. However we found ongoing concerns regarding staffing levels in the operating theatres. These are discussed in greater detail under outcome thirteen.
As Helme Chase is a midwife led unit there are strict criteria for accepting patients who will give birth on the unit. There is a strict trigger system in place to identify any concerns. If a concern is identified; patients would be transferred to another unit as soon as possible. The unit does not provide any surgical interventions or the use of forceps in assisted delivery, although staff are trained to suture minor tears to the vagina.

We talked with mothers and staff on all postnatal units about the support they had should they chose to breastfeed their babies. We found that mothers are being supported by midwives, voluntary agencies and support workers to do this. At Furness General Hospital and Helme Chase there is no specialist lead midwife to offer support and practical advice on this. Whilst this means that the specialist support service is not being consistently offered across the trust we did not find evidence that mothers were not getting adequate support on breastfeeding at all three sites.

During the visit to Furness General Hospital, postnatal ward we observed a mother was having problems breastfeeding and that the support staff were helping her. Mothers at Furness General Hospital told us they were receiving support from volunteer mothers through the ‘Sure Start’ scheme in hospital and when they went home. The volunteers came in daily on a rota basis and mothers had 24 hour access. Mothers we talked to value this support and felt is a positive thing that as these women had experienced similar problems themselves and so understood what mothers were experiencing.

There is a midwife leading on breastfeeding at the Royal Lancaster Infirmary and mothers there told us they had support and advice on breast feeding from them and from other midwives. They also had volunteer support from other mothers under a scheme called ‘star buddies’ and this volunteer support continued when they went home. One mother on Royal Lancaster Infirmary postnatal ward told us that the support she had received from the midwife with breastfeeding was “great”. Another mother told us they had “struggled” to breast feed and that she had been given advice and help from midwives and that “the night staff were fantastic”. They also said they had peer support and felt that it “really helped me to try and I can feel Ok about myself”.

We looked at what was in place on the three sites to support those who had suffered a bereavement or loss and found suitable provision had been made. At Furness General Hospital the environmental facilities available to staff were limited and not purpose designed but the lead midwife for this had developed useful and sensitive information and support packs to help people. This included counselling services and support for siblings, the women led service of ‘Listen with Mother’ remembrance services and the provision of appropriate cots.

On the unit in Lancaster we found that similar sensitive support systems were in place and in addition there were separate and designated rooms for the use of families who had been bereaved. These facilities were homely, attractively decorated and furnished with a double bed and furniture and with en suite facilities. This meant that parents needing to use the facilities at Lancaster following the
bereavement of their baby, or who had a baby with complex needs, could be alone and spend time as a family in privacy and for as long as they needed.

Our judgement
There are inconsistencies with the standards of support for mothers and families across all the three sites. However, overall, women using the maternity services did receive appropriate care and their needs and preferences were being assessed with them and planned for with them. Record keeping was of a good standard of detail.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
• Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: cooperating with others

Our findings

What people who use the service experienced and told us
Women we talked to told us that they were happy with the arrangements around their transfer for one hospital to another. They felt that the hospital worked within their birth plan to ensure they were cared for in a unit of their choice. They confirmed that when they arrived at the new unit staff were expecting them and made them very welcome and their care records were given to them for transportation between units.
Mothers at Royal Lancaster Infirmary who had been transferred from Helme Chase confirmed that they knew the reasons why.

Other evidence
Before our visits to the three maternity units we looked at all the information we held about this regulated activity within this Trust and spoke with other agencies.
We considered this outcome from the perspective of women using the service being able to have confidence that if they needed care by more than one service, team, individual or agency or a transfer between any of these that it would be safe and coordinated.

Helme Chase as a midwife led unit has specific criteria for accepting women into the
unit and mothers confirmed they are informed of this criterion and that if the need arises they would be transferred to either Furness General Hospital or the Royal Lancaster Infirmary. If there is any conflict with the criteria and patient choice there are procedures in place to discuss this between the midwives, the supervisor of midwives, consultants and the patient. The mothers we talked with confirmed to us that it had been clearly explained to them the risk of giving birth in the unit if there were any perceived complications with their pregnancy.

As a result the Helme Chase unit has agreed and established transfer procedures from and to other units. Mothers we talked with who had been transferred from Helme Chase to other hospitals felt it had been handled well and staff were ready for them. If a baby is in distress or needs extra care there is a baby transport pod which is used to support babies during transfer. There is also an agreement with the local ambulance NHS trust for emergency transfer of patients and babies to help ensure a smooth process.

We looked at what systems were in place for working with other agencies to promote the health and to safeguard and protect mothers and babies. At Furness General Hospital we looked at the work being done by midwives working with children’s centres and younger mothers and at the way public health issues were being addressed with multi agency working. Since March 2010 there have been five specialist midwives working across the trust whose remits cover the wide range of social risk.

We saw that there were systems in place or booking and reviewing women with particular needs from the substance misuse/blood borne virus senior midwife and the Mental health senior midwife. These demonstrated a woman and family centred approach to care and helped to promote effective communication with the wider multi-disciplinary team. Others covered domestic violence and we were able to see records of family team meetings for those at risk and what action midwives and social agencies and children’s services were taking to support people. They were also able to give us examples of how this had affected people’s lives in a positive way.

Records that we reviewed demonstrated an overall good level of communication and recording of care with other professionals generally in the community. GPs advised on care when there were other medical problems arising through the pregnancy. We saw that community midwives are based on the postnatal wards and there is an integrated approach being taken so community midwives work regular shifts in the hospital and cover when additional staff are needed.

Records indicate that medical staff and midwives are working together when necessary and recording their decisions about care and treatment. There is evidence of effective multidisciplinary working for example by the Caesarean Section review group, the Seniors meeting to discuss clinical practice, matron’s monthly meetings and joint working on projects across the trust and the involvement of doctors in teaching with the Midwifery practice educators. These working patterns and the work being done with other agencies and in the public health arena indicated that those providing care are cooperating and supporting the people using the services where responsibility is being shared or transferred. Our observation, records and what mothers told us indicated people were being supported to access other health and social care services and that teams were able to respond to
changing or emergency situations.

**Our judgement**
People who were using the maternity services were getting support to enable them to receive the services they needed from other health and social care providers in a coordinated way. The level of engagement and internal communication within the three sites around the handover of care of mothers and babies is effective.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance.*

What we found

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| **What people who use the service experienced and told us**
None of the mothers we talked with made any specific comments about cleanliness on the units. |
| **Other evidence**
We did not undertake a full review of the hygiene code of practice but did make observations on the maternity units about the hygiene, cleanliness and infection control measures. Overall the wards we visited were clean and being maintained and the bed areas and corridors were clutter free. Our general observations around patient areas found the floors and level surfaces clean and free from dust. We saw high level damp dusting taking place. |

However, when we visited the labour ward at Furness General Hospital we observed that the main corridor where the midwives station was situated had a large computerised system within an alcove. We saw that behind and to the side of this equipment was an accumulation of dust, dirt and pieces of cable. This was easily noticeable by anyone passing by the station. We raised this with the Matron who was not sure what the electrical equipment was for. We noted it was not a piece of medical equipment but regardless of that it should be kept clean in a clinical care environment.

It was confirmed to us by senior staff that it belonged to the video surveillance. A new system had been purchased and was due to be installed in the near future. When that had been done the other equipment would be removed. Senior staff...
confirmed that in the meantime a partition would be put in place to separate the area. It was concerning to us that this cleaning need had not already been noted and raised by the midwifery staff who have responsibility for making sure cleanliness standards are met on their shift or addressed by the management team during their walk rounds for audit purposes on the unit. It is the responsibility in healthcare for matrons or those of a similar standing to take that responsibility and accountability for delivering a safe and clean care environment.

Whilst on the labour and maternity wards we looked in the sluices and noted that at Furness General Hospital some ‘single patient use’ disposable straps, used in monitoring contractions, were being reused. In the sluice they had been washed and hung on towel dispensers to dry. Senior staff, when asked, said that this was done for training purposes but midwifery staff on the wards could not confirm this. Our observation and what staff told us indicated that they were being washed and reused with different mothers. This was pointed out as very poor practice and breaching the Code of Practice on the prevention and control of infections under The Health and Social Care Act. Action to stop this practice was taken immediately by senior staff to highlight this across the trust.

We observed good practice by staff on the wards with staff washing their hands before and after contact with patients. We saw that there were sufficient hand washing facilities in clinical areas at all sites along with appropriate colour coded waste disposal facilities and also for linen. Bathrooms and toilets we looked in were clean and bins had been emptied.

We spent time looking at theatre facilities used for maternity at Furness General Hospital and Royal Lancaster Hospital; we found them at a general observational level to be clean and well maintained.

**Our judgement**

Whilst the overall level of cleanliness across all the three sites was of a good standard at Furness General Hospital an open area of the labour ward had not been identified as in need of cleaning. Some midwifery staff were not following the correct procedures for single person use items and this could place people at risk.
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

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| **What people who use the service experienced and told us**

Mothers at Helme Chase told us, “It's lovely here, nice and quite and friendly” and “It is much more of a relaxed environment”.

No one we talked with made any specific comments about the premises and their care environment.

**Other evidence**

We spoke with staff on all the three maternity units we visited and spent time on all the units making our own observations about the safety and suitability of the premises and facilities. We also looked at information and recommendations from property appraisals that had been undertaken at Furness General Hospital in 2009.

We did not see that the recommendations in that report had been acted upon. We were told by staff that some discussions had taken place to improve facilities but these had reached no conclusive outcome.

Helme Chase is a midwifery led unit situated within the Westmorland General Hospital at Kendal. It is self contained with antenatal and postnatal accommodation and with a delivery suite. There is no theatre at this unit as it provides care for women with low risk pregnancies and labours. If patients require surgical intervention or assisted deliveries they are transferred to either the Furness General Hospital at Barrow or the Furness General Hospital at洋.
Hospital or the Royal Lancaster Infirmary depending on their choice and availability at the time.

In the ward area there are three side rooms, a ‘home from home’ birth-room and three delivery suites, one of which contained a birthing pool. On a tour of this unit we saw that this was much more a homely, informal environment compared with the more clinical labour wards at the other two sites. There was a separate lounge and dining room along with a small kitchen for mothers and fathers to use. We saw there was a sitting room that is used to assist new mum’s with breast feeding in comfort and privacy. We saw that there were sufficient bathing and showering facilities on the unit and these could be accessed by people who might have disabilities. Helme Chase staff have suitable facilities so that they can have a shower if they need to and change their uniforms if required.

At the Royal Lancaster Hospital the acute areas are on the ground floor and easily accessible. We visited and looked around the delivery suites, the post and antenatal wards and the neonatal unit.

We found the labour ward to be light and spacious with seven delivery rooms with room for necessary equipment and four of these had en suite facilities. There were suitable bathing, toilet and shower facilities on the unit to meet people’s needs. There was also a midwifery led room for ‘low risk’ deliveries. We saw the ‘high risk’ rooms had resuscitation equipment and low risk rooms had access and all rooms had equipment for monitoring mother during labour and listening to foetal heartbeats.

The unit was well laid out with rapid access to the obstetrics theatre that has its own team and with 24 hour cover. This is accessed straight off the labour ward and allows for rapid and smooth transfers for any obstetric emergencies. There was a staff kitchen, staff changing rooms and showers and a staff rest room for the use of doctors and midwives on the unit. The community midwife also has an office on the delivery suite and there is a doctor’s room and office. There was a day assessment unit on delivery suite and a separate bedroom away from busy areas for special needs, such as bereavement. This with en suite and the room we saw was attractively decorated and coordinated to create a peaceful and pleasant atmosphere for those who may have suffered a bereavement or need time to be alone and have time to adjust.

On the ante and postnatal ward there are four bays of four beds and also single rooms. One of these was designated for mothers who have had caesarean sections. There was also a breastfeeding room and facilities for storing expressed milk.

Security measures were appropriate at all the sites with key pads on doors, swipe cards for access and CCTV to monitor callers who have to be ‘buzzed’ in and out. We visited the maternity unit at Furness General Hospital. This is divided into ante and postnatal wards and a delivery suite. In the postnatal ward there are six single side rooms and three four bedded bays. One of the bays is used for dedicated antenatal care whilst the others accommodate postnatal care patients. There are
also two single side rooms, which can be used if someone needs to be kept in isolation to prevent or minimise the spread of infection. There is a family room and which can be used to support people from outside the area and suitable bathing and shower facilities suitable for people with any disabilities.

The post natal ward was light and well lit with natural light and wide corridors for easy access and a central nurse’s station. The community midwife had an office on the unit and there were suitable day rooms for mothers and clinical and office areas for staff and we found it a pleasant and welcoming place.

We also spent some time on the labour suite and made a more detailed examination of the environment for women using the service. The labour ward is entered by its own entrance and there were seven delivery rooms ready for use but the admission rooms we saw were small and with no en suite facilities so mothers have to cross the corridor to use the toilets. We saw that five of the single labour rooms were small and did not have en suite facilities and had poor natural light. We found the corridors to be quite dark and poorly lit and generally it was not a very welcoming environment and it presented as a rather dated one.

We were concerned to find that there were no disabled facilities on the unit and people needing this would have to go to the postnatal ward. Overall the one shower and bathroom on the labour ward were not adequate for a unit serving up to nine people. Although at the time of our visits all the sites were not busy.

Along the corridor is the midwives station which is also the reception for people arriving and also appears to serve as a break area for staff and general office. We saw that staff ate their lunch as they worked at the desk and held general and audible conversations. The first overall impression that we got was not a good one that reflected the latest in modern maternity provision.

However the midwifery staff do not have a separate staff room on the labour suite to take their meal breaks in and need to be able to remain on the unit for mothers and so cannot go to the canteen away from the ward. Therefore they have little choice but to congregate at the main station as there is nowhere else. We were also concerned that staff had no where to go to change out of a soiled uniform or shower on the ward if needed. From what we observed and what staff told we could see that the poor working environment would not help to make staff feel valued but that staff looked for ways to work around the problems to provide the best service they could despite the lack of modern facilities.

We found a converted delivery room that was a ‘doctor’s rest room’ which was also used for teaching and learning but that was dimly lit and unwelcoming space. Midwives did not use this room with their medical colleagues and the lack of proper facilities for midwifery and medical staff indicated to us a general lack of concern or respect for them in their working environment.

In the doctors rest room all kinds of general pieces of equipment was left and also a significant number of confidential medical records had been deposited. These were open to anyone coming onto the unit to see and tamper with. We found that generally storage facilities were not sufficient throughout the unit. The doctor’s room was originally intended to be the theatre in labour ward but was not commissioned when the unit opened in 1985. There is still no theatre on the labour ward and the
main theatre is used and is accessed via two main public corridors.

Next door to the doctor’s room was a room that could be used for families with a special need, such as for privacy or following bereavement. This was a clinical looking delivery room and bed with a sofa in it that could be converted to a bed. Like all the labour rooms it had poor sound proofing. Staff also told us that ventilation on the unit was poor and the heating was not sufficient in winter. Overall this unit lacked the layout and facilities that are conducive to providing modern maternity care.

Our judgement
The people using the labour ward at the Furness General Hospital site are inconvenienced and may be disadvantaged because of an outdated care environment and poor arrangements for people to access facilities. People may feel exposed and restricted as the environment does not offer modern facilities to support the more complex needs of families who may need privacy. It does not meet staff needs for a suitable work environment or fully meet the needs of people with disabilities.
Outcome 11: Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

No one we talked to who was using the maternity services made any comment on the equipment in use or how staff used it.

Other evidence

We did not look at this outcome area in specific detail during our visit but made general observations and spoke with staff about use.

In Furness General Hospital we were told that training on any new equipment is usually undertaken within the department, usually by trainers for the company who supply the equipment. We saw that resuscitation equipment in theatre and on the wards had daily checks and portable appliance testing had been done (PAT test).

At the Royal Lancaster Infirmary we saw evidence of competency statement records for assessing staff to demonstrate they know how to use any new piece of equipment. These statement records are staff individualised and are completed to demonstrate that staff are aware of how to use the equipment and identify any problems with it. When completed this record is signed both by the practitioner and the assessor. Staff confirmed to us that they felt appropriately trained in the use of medical devices. There are dedicated link midwives for equipment training. At Helme Chase staff also confirmed they received appropriate training for all
equipment and that they felt competent to use it.

We saw there is appropriate ante natal and post natal equipment available at the three sites. There is access to heart monitors, resuscitators for babies, an incubator and also resuscitation equipment for adults. Staff at all units confirmed that they conduct daily checks to ensure that equipment is available and working correctly. We saw at Lancaster and at Furness General hospitals that there were emergency equipment checklists in use signed daily and that the emergency drugs we saw were sealed and within date.

Our judgement
From what we saw appropriate equipment to meet people’s needs is being provided and maintained and staff were being trained in its use.
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 major concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

Women on all three sites told us that they felt supported by staff at all times. All those we spoke with told us they had the support of their midwife on a one to one basis during the latter stages of their labour. They told us that they felt that staff were very supportive and always had time to help, although they did recognise that at certain times staff were kept busier than at others.

One person said, ‘When I was in Barrow the staff always answered my buzzer very quickly’

Other evidence

During our visits to all three sites across the trust we found that all the labour wards were quiet which had an effect upon the way that staff were being utilised. On the day of our visit to Helme Chase there were two women in the postnatal unit and one in the delivery suite. Staff levels were appropriate with two midwives on duty during the day supported by maternity assistants and at night usually one midwife on duty and two maternity assistants. We were told that staff in the unit are a mixture of ward based and community based staff and although there were no dedicated bank staff, midwives from the community and other sites were willing to work in the unit to ensure that adequate staffing numbers could be maintained. Staff also told us that
the new identification system for specific midwives to be on call and able to come and assist in the unit was working very well and it enabled a quicker response to staff issues.

At the Royal Lancaster Hospital ante and postnatal unit on Ward 17 staffing levels aimed for two, ideally, three midwives during the day with maternity assistants and at night two midwives and assistants. On the labour ward we spoke with the ward coordinator and staff and they told us that they felt that there was good staff support between the midwives. They told us that it was a small unit and that everyone worked very well together, and that in the main all midwives had been there for a considerable amount of time. It was quiet on the day we visited with two mothers in labour.

We were told that students seconded to the trust for their midwifery training are advised that during the time they are with the trust they could work on any of the three maternity units. This expectation is now being included in the new band 5 midwife (junior midwives) contracts with staff expected to rotate, at least in their first year, to each unit on a quarterly basis. Staff and doctors rosters at the Royal Lancaster Infirmary were adequate, we saw that there was always a band 7 midwife (senior midwife) on duty at all times. For medical cover there was always a senior house officer for obstetrics, supported by a registrar for obstetrics and gynaecology. We could also see there was a rota for night supervisor cover for midwives.

We noted that there have been times when staff capacity issues at Royal Lancaster Infirmary has meant the labour ward has been unable to take more mothers. When this occurs a contingency plan to divert mothers in labour is used when the labour ward is full or the staffing available is not able to cover. This is part of the maternity risk management strategy and the escalation staffing policy. We noted that these policies were still in draft form at the time of our inspection.

We looked at the information supplied to us by the trust and their figures on the Birth rate plus midwifery staff calculation tool. This is a tool that enables maternity units to calculate the staffing level needs based on the number of deliveries per year. The staffing at Furness General and Helme Chase maternity units were only very slightly below the numbers stated but at Lancaster staff levels were below and figures indicated 2.18 whole time equivalent staff down. We were given information that indicated that the Lancaster unit operates at 90-95% capacity most of the time.

We talked with a range of staff at Furness General and they were able to confirm that Lancaster diverted patients “most often” and that this did put pressure on them at times. The previous weekend of our visit Furness General had been very busy and labour ward was full and staff told us they needed to divert people to Lancaster. They told us this was the first time they had needed to do that. This indicates a safe approach being taken to managing high levels of maternity activity.

One of the mothers who was admitted during that busy weekend told us that the staff had been very busy but they felt, “despite that they were there for me”.

We did not see anything to indicate that the staff available on the days we visited the units were not sufficient to meet people’s needs. However it must be noted that we were not there observing, during a busy period with midwives going to support mothers in theatre as well as labour with several mothers in labour. At both the Furness
General Hospital and the Royal Lancaster Infirmary midwives from the ward were expected to assist with the baby within theatres. This can have the effect of further reducing the number of midwives available on the ward for up to an hour or more. Staff would come in at short notice and community staff could be accessed for help, although that might have time implications. We found on all the three sites that staff good will in working flexibly and at short notice was central to making sure staff levels remained in place for women using the service.

Staff also told us that the length of time they needed to keep up the high level of record keeping and document everything they needed to was considerable and often resulted in them working well beyond the end of their shifts. Record keeping was of a good standard across all three sites and obviously maintaining such a standard takes time to complete but doing that should not keep midwives from being with mothers.

There was the risk to maternity patients due to unsatisfactory arrangements in theatre staffing rotas and the staff provision for dealing with emergencies. The present staffing levels and theatre staff capacity at the Furness General Hospital site could impact on the maternity service delivery. There is only one ‘out of hours’ team available 24 hours over seven days a week for theatres and no second emergency team if that team is already occupied with an emergency. All specialities are covered by one team and there is no dedicated obstetrics.

We asked what happened when this situation arose and what contingency plans were in place to make sure that there were always sufficient theatre staff to make sure the needs of people who were using the service could be safely met. We had information regarding a recent serious untoward incident when obstetric cover was compromised for a woman who needed access to theatre but there was already a general trauma case on the operating table. The staff in theatre telephoned around all staff to try and get people in and were unable to get cover, therefore the theatre staff team on duty had to be split across two theatres.

The chief executive and the director of nursing have stated that plans for a second on-call team for theatres in Furness General Hospital will be taken forward and will be in place by September 2011.

We also noted at the Furness General site that there is a staffing issue over the medical cover available for paediatrics on the maternity unit due to unfilled posts. At present paediatric consultants ‘act down’ to provide cover and this puts extra strain on them with workload. The trust is responding to changing circumstances within the workforce and there is currently a major recruitment drive to stabilise this area. In the meantime the solutions are being supported in the short term by staff good will. This poses a risk to the sustainability of what should be a short term solution in terms of staff morale and the working time directive.

Judgement.
Our observations, speaking to staff and reference to the risk registers for the operating theatres clearly indicated that there were problems associated with having only one emergency team available out of hours and at weekends. Staffing in theatres was not adequate to cover out of hours. Whilst people may not as yet have
come to harm in such situations they were being put at risk and may have received a substandard level of care due to insufficient numbers of staff in the theatres. They may also have experienced delays in receiving the care they needed.
Outcome 14: 
Supporting workers

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 workers

Our findings

What people who use the service experienced and told us
The mothers we spoke with made no specific comments about staff competence, training or supervision.

Although we did not specifically speak to mothers and their partners about this outcome but over all the mothers we did speak to were happy with the support and care they received from doctors and midwives. The felt their care was appropriate and safe and they were given advice and information to enable them to make choices.

Other evidence
When we spoke to staff at Helme Chase they confirmed that there was no problem with training and across trust training had helped in improving relationships between the three hospital sites. Staff confirmed they had undertaken advanced life support and obstetrics training. We were also told that if certain training was identified as a requirement through professional development reviews monies would be sourced to support this. However there was some concerns voiced that due to the changes in midwifery banding and responsibilities earlier in the year that staff had not always received the support and guidance to fulfil their new roles as expected.

Staff across the three maternity units could confirm they had access to annual appraisals which supports development and training in the unit. The staff we spoke to had received an appraisal and confirmed that they received mandatory training.
There is a delivery structure in both midwifery and medical appraisal framework. The midwifery team has a number of midwifery practitioner trainers who work across all hospital sites. They support the delivery of mandatory training, specialist updates and training events. Feedback received indicated that these midwives are highly regarded by their peers. We saw an example of innovative training and development that was identified by the NMC adviser when they spoke to a community trainer. They had provided an obstetric emergency drill in a home set up which allowed staff to consider managing problems in a controlled environment and work out solutions. The evaluations from midwives were very positive in both the relevance to their practice and the benefits in supporting their practice development.

The trust has undertaken a re-design of the midwifery structures within the division with the aim of developing the midwifery role and leadership and they have appointed a new head of midwifery. This new structure and leadership is enhancing the team dynamics in midwifery. The development of senior midwives with a lead in public health and a new leadership development pathway has been fully implemented since November 2010. We observed the leadership of staff on the wards and units and spoke with senior midwives and matrons during our inspection. We were told by staff that the new structure and flexible leadership across hospitals, within the matron’s roles was ensuring a joined up approach to learning and sharing best practice. For example there are integrated risk meetings and there is a cross site representation by midwifery staff.

Supervision of midwives is a statutory function professionally regulated by the Nursing and Midwifery Council. The Supervisors of Midwives (SOM) role is to provide guidance and support to both midwives and mothers alike. The supervisors support the practice of midwives and ensure that the care offered is safe and effective for both the mother and baby. If a midwife requires additional education, training and support in practice, a Supervisor can recommend a formal programmed of supervised practice.

There was information available about the supervisors of midwives on the units and photographs. The mothers we spoke with were aware of there being supervisors but they were not aware of what that meant for them in practice and how it could help them.

We identified from the information available to us that there are satisfactory arrangements in place to make sure staff are receiving appropriate training, appraisal and supervision. Although there may be a need to raise the profile of supervision generally with mothers as well as at Board and Senior Management levels.

**Our judgement**

We found that people using the maternity services were being supported by staff who had received appropriate training, appraisal and supervision. They were being supported to maintain and develop their skills relevant to the work they were undertaking.
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

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What people who use the service experienced and told us

People we talked with on the maternity units did not raise any concerns and made no specific comments relating to this outcome area.

Other evidence

The trust has a formal risk management structure in place which crosses all three hospital sites. This structure should enable the Trust Board to manage the delivery of quality care. The Trust Board has delegated overall responsibility for clinical risk management to the Clinical Quality and Safety Committee and this is chaired by the Medical Director of the trust.

The Trust has a system in place for issues and risk to be escalated by staff to the senior managers, medical leads and matrons and placed on the local risk register; this is a register which holds details of the areas of concern, the level of risk and likelihood of occurrence, along with the actions taken to reduce the likelihood of this issue/problem happening again.

This risk register is owned and managed by the senior staff on each department and ward. The risk register is a ‘live’ report which enables staff to record and monitor
their known risks and issues. Actions should be put in place to reduce any associated risk.

The risk management structure allows for issues which cannot be solved locally and where there is a high level of risk to be escalated on to the divisional risk register, held by the Associate Medical Director and Management team and then finally the division may escalate concerns and risk onto the corporate register, overseen by the Trust Board. This should ensure that the trust board has knowledge of all high risk issues. The trust currently recognises a high level of risk within the staffing establishment of paediatric medical staff and there is currently a recruitment drive to stabilise this area along with concerns in relation to the storage of medical records.

We reviewed the risk registers for the operating theatres as we had concerns about the staffing levels and capacity at the Furness General Hospital site which is impacting on maternity service delivery. We found that risk registers are not always kept up to date and were not integral to the every day management of risk.

The registers we saw on site and the ones provided by the trust after our visit had not sufficiently progressed over a time period from October 2009, the department had rated staffing capacity concerns as ‘8’ which means that this risk would be managed by the division and would not be escalated to the corporate risk register. The register had not specifically identified the problems associated with only having one emergency team available out of hours and at weekends.

There has been a failure to recognise the risk to patients due to inadequate arrangements in theatre staffing rotas. We observed one near miss whilst we were in the hospital when a doctor was undertaking a surgical gynaecology emergency case in theatre and was therefore not available to support a midwife on labour ward. We were also provided with other scenarios, from staff, that had occurred recently which identified the pressure to deliver a variety of trauma and emergency surgical work, along side the staff flexibility required to manage obstetric emergencies and urgent cases in the theatre.

It was evident that theatre staffing at the Royal Lancaster Infirmary site and the actions this hospital undertakes to cover obstetric surgery were different to Furness General Hospital.

The divisional and departmental risk registers that we looked at did not clearly identify the risk of operating with one emergency team out of hours and at weekends nor did we see any indication that the incidences and near misses were monitored effectively. If they had been monitored effectively, the issues we found during this review would have been escalated to the corporate risk register for discussion and action.

When a care pathway does not have the expected patient outcome and people experience significant harm the trust report the ‘serious untoward event’ to the commissioning primary care trust (PCT). The PCT is responsible for monitoring the number of events and evaluating progress by the trust on their actions taken to
minimise and prevent reoccurrence. We spoke to the North West Strategic Health Authority, commissioners in North Lancashire and Cumbria about the maternity incidents that have been reported to them between 2010 and 2011, there have been no concerns about the numbers of incidents or with progress the trust has made with the action plans.

The trust commissioned a review of its clinical governance arrangements, including serious untoward incidences that occurred in maternity services in 2008. This review was undertaken by three external maternity professional experts and was called the Fielding Review (finalised August 2010). The review identified many areas for improvement and change along with issues relating to the ‘culture of team working’. A recent Rule 43 letter from the Coroner also raised an ongoing concern about the team working in the maternity services along with concerns in relation to record keeping, pressure of work and continuity of care.

As part of our review we spoke widely with many various staff, across all professional groups and assistant roles, to community teams and other groups and agencies who provide care to mothers, to establish if team working was effective and integral to care delivered to Mothers and babies. We observed care delivery and reviewed case notes. We also worked closely with the Nursing and Midwifery Advisors who looked at the delivery and effectiveness of statutory supervision of midwives.

We found that generally mothers and babies are receiving safe and effective care, treatment and support across all three hospital sites because staff undertake individualised care assessment, plan and monitor the care and its effectiveness as part of a multi-disciplinary team at each site. This means doctors, midwives and other clinical staff work closely together within their own hospitals to ensure care is as safe and effective as possible at the point of delivery. Therefore the teams are working well together at their respective hospital sites.

The medical staff we spoke to provided examples of the inconsistent application of guidelines. For example the epidural service run at both the Royal Lancaster Infirmary and Furness General Hospital have different protocols. And trust wide guidelines on the hospital intranet are not always agreed and implemented within the paediatric department.

Throughout the time of our inspection and when we spoke to other external agencies and other health care professionals, who worked closely with the maternity teams in the three areas, there was a recognised problem that was repeatedly emphasised and attributed to poor inter medial staff relations in particular across the two main acute sites; Furness General and Royal Lancaster.

Monitoring quality and outcomes can come from a variety of pathways for example staff can raise concerns and issues through the appraisal system. When we spoke to senior medical staff about what is identified to them through the appraisal system by other doctors, no issues were recorded.
We asked to see the maternity local, divisional and corporate risk registers to see if any of the concerns we had identified during this review had been reported. We were not able to see the ‘live’ maternity risk register on site as the person who leads on managing risk in the unit was on annual leave and other staff could not access this information. This person also held access to some policies and guidelines which has recently been updated but had not been shared with staff.

During our review we looked at how risk assessment, incidences and concerns were raised by staff and patients, what actions resulted from these and how the board members were made aware of the high risk issues. We also followed up on the actions taken to address these concerns.

We found midwifery staff routinely report incidences at all three hospital sites via the trust electronic system and these were then forwarded to senior midwives, doctors and matrons who would consider and take forward further evaluation of the events. The end result often led to changes in practice and lessons learnt with updates to guidelines and training. However we did identify a concern that the distribution list for the alert email system to senior midwives, doctors and supervisors of midwives was wide, there was no formal mechanism for identifying who would review the incidences and that the alerts also contained incidences from the gynaecology wards. The midwifery staff and supervisors do not need to receive these.

When we spoke to staff they were all familiar with the various systems and ways of reporting issues and incidences but some staff commented that ‘not a lot ever happens when we report some of our issues’. This was collaborated by some areas of concerns we identified during our observation and our walk about of the wards, for example the storage of medical records on the delivery suite had been raised as a concern for many months but no action had been taken to address the storage and managed destruction of case notes.

We did find examples of good practice to inform and update staff of changes and actions taken as a result of their reporting. There is a newsletter regularly issued to staff which provides information on the various incidences and actions taken to learn and prevention re-occurrence. There are also several local maternity risk management meetings and labour ward review meetings / forums which ensure issues and risk are widely considered by the multi-disciplinary team.

We observed an inconsistent approach to reporting ‘near miss’ events. These are events involving patients which may not have had a negative outcome because someone or something stopped / prevented the problem occurring. It is widely acknowledged that reporting and learning from ‘near miss’ events help to prevent serious untoward incidences from occurring. When we spoke to the medical director about this they were aware that the trust needed to target this area.

CQC has issued a Warning Notice which requires the University Hospitals of Morecambe Bay NHS Foundation Trust to take action by 21st November 2011 to meet the regulatory requirements. If this is not achieved further enforcement action may be taken.
Our judgement
The maternity and midwifery services have systems in place to evaluate and monitor care delivery and practice. Actions arising from the monitoring do not always take place in a timely manner. There are risk registers in place, however, these are not consistently applying a rating nor are concerns escalated to the most appropriate management level. There are gaps preventing escalation of concerns and staff are not always reporting near miss events. The trust is therefore reacting to events rather than promoting a preventative/proactive culture.

We found that the medical team do not always work effectively within the clinical governance and leadership arrangements across all three sites. This means that sometimes clinical leadership and integrated working does not always achieve consistent approaches, for example medical staff are not always developing and delivering evidence based guidelines consistently across all three hospitals.

Relationships between some senior medical staff in certain areas did not demonstrate a joined up approach to working together. The impact of this was found to be negligible on patient care however long term inconsistencies and divisions may increase the risk of a two tier service which will not meet nationally recognised care pathways.
Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us

People we talked with on the maternity units did not raise any concerns and made no specific comments relating to this outcome area. However one person told us ‘When I was transferred between units, staff gave me my records in a big brown envelop to take with me.’

Other evidence

We looked at people’s care records at all three of the maternity units across the trust and overall these records demonstrated that there good recording systems in place within the separate units. We were able to see a woman’s journey from community antenatal care, through admission, delivery, transfer and postnatal care. We saw that there was a birth plan in place, where women had chosen this, and it was being used and followed as far as possible. There were clear recordings of discussion with women, risk assessments, the decisions being taken and the reasons why they were made during labour.

We saw that the same format of care records where used across the trust and this has helped with consistency in care management and recording. Staff told us that the use of uniformed notes does ensure everyone is “singing from the same hymn
sheet” but does take away some of the individuality. However the ongoing notes are very thorough and were being kept safely and with mothers on the units.

While we were making a tour of the labour ward at Furness General Hospital we went into the ‘doctor’s rest room’ and that found significant number of medical records had been deposited there on shelves and trolleys. We were concerned about such a large quantity of confidential medical records that were not being held securely.

Midwifery staff told us that the inappropriate storage of medical records had been recognised as a major issue by them before our visit and they had “escalated” their concerns over a period of months. Staff had made requests for the documents to be taken away from the delivery suite and stored appropriately. This had not been addressed and we found that the delay in addressing this was due to financing medical records movement storage and sorting.

It was evident that staff were not listened to when they raised this concern and the incidence does not seem to be an isolated one for example the concerns we have identified in outcome 1 and 10. Staff we talked with indicated that they did not feel that raising an issue had much effect in general and so they “just got on with it”.

Some of these general medical records dated back to 1965 and therefore the trust has not implemented the relevant guidance on the length of time that such records need to be retained and securely destroy records when it is appropriate.

Following our discovery of these records actions were taken by the director of nursing to make the location more secure and steps taken to organise a transfer of the records to an appropriate and secure location.

Our judgement
Whilst there was evidence amongst midwifery and medical staff of some good practice in completing and keeping records of care patient we saw that the approach taken to storing and managing some medical records was not robust. Some records were not always being stored securely and managed in people’s best interests.

The trust has not considered its practices and its responsibilities in relation to the current legislation protecting confidential information and also the codes of practice in relation to records management and information governance. This breach of data protection indicated to us a lack of rigor, oversight and accountability within the trust in this respect.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
<th>How the regulation is not being met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 17</td>
<td>Outcome 1: Respecting and involving people who use services</td>
<td>Current practices at Furness General site in relation to the transfer of women to theatre for emergency obstetric procedures do not ensure their privacy, dignity and safety. Information is not being given to women regarding the facilities in use should they need an emergency transfer to the theatre suite so they could not make an informed choice or provide their views on these arrangements.</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 12</td>
<td>Outcome 8: Cleanliness and infection control</td>
<td>At the Furness General Hospital an open area of the labour ward had not being identified as in need of cleaning. Some midwifery staff were not following the correct procedures for single person use items and this could place people at risk of cross infection.</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 15</td>
<td>Outcome 10: Safety and suitability of premises</td>
<td></td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 22</td>
<td>Outcome 13: Staffing</td>
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>People using the labour at the Furness General Hospital site are inconvenienced and may be disadvantaged because of an outdated care environment and poor arrangements for people to access some facilities. People may feel exposed and restricted as the environment does not offer modern facilities to support the more complex needs of families who may need privacy. It does not meet staff needs for a suitable work environment or fully meet the needs of people with disabilities.</td>
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<table>
<thead>
<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 10</th>
<th>Outcome 16: Assessing and monitoring the quality of service provision</th>
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</thead>
<tbody>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Our observations, speaking to staff and reference to the risk registers for the operating theatres clearly indicated that there were problems associated with having only one emergency team available out of hours and at weekends. Staffing in theatres was not adequate to cover out of hours. Whilst people may not as yet have come to harm in such situations they were being put at risk and may have received a substandard level of care due to insufficient numbers of staff in the theatres. They may also have experienced delays in receiving the care they needed.</td>
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</table>

We found that the medical team do not always work effectively within the clinical governance and
leadership arrangements across all three sites. This means that sometimes clinical leadership and integrated working does not always achieve consistent approaches, for example medical staff are not always developing and delivering evidence-based guidelines consistently across all three hospitals.

Relationships between some senior medical staff in certain areas did not demonstrate a joined up approach to working together. The impact of this was found to be negligible on patient care however long term inconsistencies and divisions may increase the risk of a two-tier service which will not meet nationally recognised care pathways.

<table>
<thead>
<tr>
<th>Maternity and midwifery services</th>
<th>Regulation 20</th>
<th>Outcome 21: Records</th>
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</thead>
<tbody>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
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<tr>
<td>Some records were not always being stored securely and managed in people’s best interests.</td>
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<tr>
<td>The trust has not considered its practices and its responsibilities in relation to the current legislation protecting confidential information and also the codes of practice in relation to records management and information governance. This breach of data protection indicated to us a lack of rigor, oversight and accountability within the trust in this respect.</td>
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</tbody>
</table>
Enforcement action we have taken to protect the welfare and safety of people using this service

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
<th>To be met by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and Midwifery Services</td>
<td>Regulation 10</td>
<td>Outcome 16: Assessing and monitoring the quality of service provision</td>
<td>21\textsuperscript{st} November 2011</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulation or section is not being met:</th>
<th>Registered manager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maternity and midwifery services have systems in place to evaluate and monitor care delivery and practice. Actions arising from the monitoring do not always take place in a timely manner. There are risk registers in place, however, these are not consistently applying a rating nor are concerns escalated to the most appropriate management level. There are gaps preventing escalation of concerns and staff are not always reporting near miss events. The trust is therefore reacting to events rather than promoting a preventative/proactive culture.</td>
<td>NA</td>
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Relationships between some senior medical staff in certain areas did not demonstrate a joined up approach to working together. The impact of this was found to be negligible on patient care however long term inconsistencies and divisions may increase the risk of a two tier service which will not meet nationally recognised care pathways.

The provider must send CQC a report that says what action they are going to take to achieve 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 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance 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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
<td>The general public</td>
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### Care Quality Commission

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<tr>
<td>Telephone</td>
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<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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| Postal address   | Care Quality Commission  
|                  | Citygate       |
|                  | Gallowgate     |
|                  | Newcastle upon Tyne |
|                  | NE1 4PA        |