University Hospitals of Morecambe Bay NHS Foundation Trust
Furness General Hospital

<table>
<thead>
<tr>
<th>Region:</th>
<th>North West</th>
</tr>
</thead>
</table>
| Location address:| Dalton Lane  
                     Barrow-in-Furness  
                     Cumbria  
                     LA14 4LF |
| Type of service: | Acute services with overnight beds |
| Date of Publication: | September 2012 |
| Overview of the service: | The trust operates from three main hospital sites: Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital.  
Accident & emergency departments, critical/coronary care units, maternity services and consultant led beds are available at Barrow and Lancaster. All |
| three sites provide a range of planned care including out-patients, diagnostics, therapies, daycase and inpatient surgery. In addition local outreach services and diagnostics are provided in the community. |
Our current overall judgement

Furness General Hospital was meeting all the essential standards of quality and safety inspected.

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

Why we carried out this review

We carried out this review to check whether Furness General Hospital had taken action in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 08 - Cleanliness and infection control
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 14 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

This report concerns the Furness General Hospital maternity unit.

Women we spoke with were all pleased with the level of care they had received.

One woman told us "I have no problems. I am happy with the service. I have been given lots of explanations and information. I have had no problems or concerns about lack of privacy or dignity."

As part of our inspection we spoke with local stakeholders such as the local councils Overview & Scrutiny Committee who have a duty to look more closely into public services outside their own organisation which includes local NHS hospitals. They said they had not received any concerns from the public about Furness General Hospital or the Royal Lancaster Infirmary maternity units in recent months. They told us they had regular meetings with senior staff at University Hospitals of Morecambe Bay Trust which kept them up to date with any changes in service provision at the trust.
We also spoke with the Local Involvement Networks (LINks) who had not received any issues or concerns from the public about the provision of maternity services at University Hospitals of Morecambe Bay.

We inspected Furness General Hospital (FGH) maternity unit to check compliance with a warning notice served in August 2011 and to follow up compliance actions from the last inspection report. We had issued a warning notice and compliance actions across FGH and Royal Lancaster Infirmary Hospital (RLI) maternity units. A separate report has been written for FGH. Although the previous report highlighted some different issues for each site there were common themes identified therefore it is beneficial to read this report in conjunction with the one for RLI.

The trust had made good progress in addressing our concerns contained in the warning notices and compliance actions from last year. It was evident that the trust was working with staff to develop a safe, women centred, evidence based maternity service. Good practice points were noted across both The Royal Lancaster and Furness General Hospital sites.

Clinical staff involved in the inspection gave us honest, helpful and well considered explanations. They were able to support their answers with robust examples and both written and verbal evidence. They demonstrated excellent skills in relationship building throughout the two days and were warm and welcoming.

Work is still ongoing, which is to be expected, around cultural change, staffing levels and data management systems but significant progress has been made to address these.

**What we found about the standards we reviewed and how well Furness General Hospital was meeting them**

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

The trust was meeting this standard.
People's privacy, dignity and independence were respected.

**Outcome 08: People should be cared for in a clean environment and protected from the risk of infection**

The trust was meeting this standard.
People were protected from the risk of infection because appropriate guidance had been followed.

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

The trust was meeting this standard.
People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

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

The trust was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

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 trust was meeting this standard. The provider had an effective system in place to regularly assess and monitor the quality of service that people receive.

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

The trust was meeting this standard. Records were kept securely and staff were aware of their responsibilities in relation to current legal requirements and professional best practice.

Other information

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

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

Our findings

What people who use the service experienced and told us
There were no women available for us to speak with who had needed to be transported in an emergency to theatre. However we spoke with two women in general about issues of privacy and dignity.

Both women told us they had had no problems regarding privacy and dignity. They felt that every member of staff went out of their way to ensure their privacy.

Other evidence
We last inspected maternity services on 18 July 2011 when we found moderate concerns around the privacy and dignity of women in labour. This related to when women needed to be transferred to the general theatres for an emergency obstetric procedure (there was no designated obstetric theatre within the maternity unit). Women had to be transported through a busy public corridor on a hospital bed. In some cases women in labour needed intimate physical assistance from their midwife as they were transported. Staff had told us they had raised the concern with senior managers many times but were told as nothing could be done about it they just had to get on with it. We had found no evidence that women were given any information about the transfer arrangements verbally or through written information. We had informed the trust that it was not meeting this standard.
The trust wrote to us and told us interim arrangements would be put in place using maternity support workers and porters to clear the area of the general public prior to any emergency transfer. All adjacent offices would be requested to close their doors during transfer. A detailed risk assessment of emergency transfer to theatres would be undertaken from the perspective of the women. Patient information leaflets would be reviewed to ensure women were fully informed of the arrangements for emergency transfer to theatres, with midwives providing the information verbally with immediate effect. User feedback surveys would be introduced for all women who experienced an emergency transfer to theatre.

At our unannounced visit on 14 August 2012 staff told us there was now a process in place to address the problem of a lack of privacy and dignity during the emergency transfer process. The delivery suite backs on to the medical assessment unit (MAU) via locked double doors and the route taken now goes from the delivery suite through the MAU. We watched a simulated exercise where a member of staff rang through to the MAU saying they had a woman who needed to be transported in an emergency to the theatre. A support worker on the MAU immediately closed all doors and pulled curtains across all areas in the MAU to leave the ward corridor free from general observation. Once at the end of the MAU the hospital bed then travelled a very short distance, no more than a few yards across the public corridor. To prevent public access across the corridor whilst a woman was being transported, two sets of curtains were pulled across each side of the corridor. We saw that this procedure was undertaken very smoothly and speedily and provided privacy and protected a woman’s dignity. This would also be the route used for any infant bereavement transfers from theatre back to the maternity unit which now gave more privacy for a bereaved mother.

We spoke with staff about the plans they had in place if for some reason they were unable to transport a woman through the MAU, for example if there were people with infection control issues on the MAU. One midwife told us this had happened and she had made the decision that the main public corridor would have to be used. This had been the original way we felt had not protected a woman’s privacy and dignity. However this midwife and a second midwife supported her saying that in an emergency there was nothing else that could be done. They also said they would ensure that as much would be done as possible to ensure the woman’s dignity was maintained if this had to happen. They both said that a clinical incident form was completed when this did happen and the situation was monitored closely. This situation was now a rarity and a risk assessment had been produced to cover this eventuality.

We spoke with three midwives who said that all women who had to be transported to theatre in an emergency were told in advance of this happening, and afterwards they were given a ‘Transfer to theatre patient experience survey’ form to complete. This form asked them whether they had been made aware of the emergency procedure before they went to theatre and whether they felt all was done to protect their privacy and dignity during the transfer. They were also given the opportunity to make suggestions to improve that part of the service. We looked at a sample of the survey forms completed and found there had been no worries about privacy and dignity raised by women who had to be transferred to theatre in an emergency.

The midwives we spoke with told us they were much happier with the way the system of transfer worked now.
Our judgement
The trust was meeting this standard.
People's privacy, dignity and independence were respected.
Outcome 08:
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

Our judgement
The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We spoke with three women in general about cleanliness on the maternity unit. They all told us the unit was spotlessly clean. None of them had any concerns about cleanliness and infection control.

Other evidence
We last inspected maternity services on 18 July 2011 when we found moderate concerns around an accumulation of dust and dirt on some redundant video surveillance equipment in the delivery suite. We noted at the time that midwifery staff had not taken responsibility for making sure cleanliness standards were met.

We also had concerns that single use disposable straps used in monitoring contractions were being washed and reused on different women. This breached The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. This practice was stopped immediately when we pointed this out to senior staff at the time of our first visit.

The trust wrote to us and told us that the area with the dusty video surveillance equipment had been cleaned and the equipment had been covered to prevent any further accumulation of dust. All reused straps had been disposed of and an alert notice had been circulated to all sites reinforcing advice about single use equipment. All women requiring fetal monitoring were provided with a set of straps, which they kept throughout their pregnancy and labour; these were kept within the woman's medical records for use as and when required, and then disposed of at the end of her stay.

At our unannounced visit on 14 August 2012 the maternity unit as a whole was seen to
be clean and tidy. We saw staff washing their hands before and after contact with women. There were sufficient hand wash facilities in clinical areas along with colour coded waste disposal bins. Bathrooms and toilets were clean. There were full foam hand gel sprays at the entrance to all wards and entrances for visitors and staff to use to help prevent hospital acquired infections.

We saw no evidence that single use disposable straps were being reused.

We looked at minutes from the hospital management team meeting for July 2012 where we could see that the infection prevention and control committee minutes were discussed and noted. This showed that the senior management team within the hospital were made aware of governance issues and were seen to monitor progress across all sites.

**Our judgement**
The trust was meeting this standard.
People were protected from the risk of infection because appropriate guidance had been followed.
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

Our judgement

The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We spoke in general with four women on the delivery suite and in the ward who felt the area was bright and that the facilities were "fine".

Other evidence
We last inspected maternity services on 18 July 2011 when we found major concerns around the premises. The delivery suite was dated and did not provide a welcoming environment. The delivery rooms looked small and not all had en-suite facilities, which meant mothers, had to cross the corridor to use the toilets. Some of the rooms on the delivery suite were poorly lit. There were also no disabled facilities available on the unit. We voiced some concern over there being only one shower and one bathroom available for use as well as the two en-suite rooms for nine women when the labour suite was full.

Staff tended to congregate at the midwives’ station (which also acted as a patient and visitor reception) to have general discussions and for meal breaks. This did not give a good first impression and did not reflect the latest in modern maternity provision. However, midwifery staff did not have a separate staff room on the delivery suite and as they needed to be available on the unit they had no other choice. We found a converted delivery room that had been used as a doctors’ rest room / teaching area but this was a 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, general equipment had been stored, as there was limited space to store equipment elsewhere.
Staff told us that ventilation was poor and heating was not sufficient in the winter. Overall we felt the unit lacked the layout and facilities that were conducive to the provision of modern maternity care.

The trust wrote to us and told us they would review the existing project plans to ensure they would provide a fit for purpose maternity and paediatric unit. They also told us they would prepare an operational plan for reconfiguration of the delivery suite and undertake an options appraisal taking the views of all stakeholders and looking at all aspects of the service. The preferred options would be formally considered for implementation by the Trust Board. We received an update from the trust, which said they were undertaking a wider maternity review looking at the long term delivery of services across south Cumbria with the new Clinical Commissioning Groups (CCGs). CCG’s are groups of GPs that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning or buying health and care services. Therefore, the trust’s original plan to review the existing estate plans for maternity and paediatrics would take longer. We were made aware that some improvements to the delivery suite facilities had been made to modernise the premises.

At our unannounced visit on 14 August 2012 we looked around the delivery suite. The unit was well lit (extra lighting had been installed) and rooms looked fresh and clean. The doctors’ rest room had been refurbished; it was light and fresh looking with new flooring, lighting and seating. There was a table to eat meals at and there was a kitchen area where staff could make refreshments. This room was used by all maternity staff for breaks and was also used for teaching and audit meetings. A white board, notice board and a computer was available for staff to use in this area. Midwives and doctors told us they really liked having this facility available to them.

Staff on the delivery suite had been included in discussions about the refurbishment of the labour ward, the new equipment purchased and about the use of the rooms. One of the new senior midwives told us she had been able to get one of the rooms made into a ‘triage room’. This meant that an assessment of a woman coming into the delivery suite could be made and her birth plan could be discussed with her, rather than her being placed straight into the first available delivery room. The midwife told us this reduced the times a woman had to be moved around the labour ward and ensured she had access to the most appropriate room for labour as some of the delivery rooms were designated for different types of birth. For example, one room was kitted out with a pool for water births, and some rooms were more suitable than others for women who wanted an epidural. An epidural is a form of anaesthesia that gives continuous pain relief throughout labour and delivery, but means that a woman is comfortable and fully awake for the birth. New equipment was available in the rooms such as wall mounted resuscitation units, which reduced the amount of equipment standing on the floors.

Storage areas had been revamped and there was plenty of equipment in stock. Two members of staff told us they did not run out of equipment any more. A midwife told us they were in the process of looking at reducing the amount of stock carried on the delivery suite as it was unnecessary when daily deliveries for most stock could be obtained. This she felt might help utilise space better and control costs.

A new staff office had just been commissioned and staff were in the process of moving equipment into the room on the day of the inspection. This office was a large open plan space with a wall mounted work station that wrapped around three walls with computer
terminals and seating. There was a white board for communications about individual's care and staff had asked for a roller blind to be fitted above it so when no-one was in the office it could be pulled down to provide confidentiality of patient information. The office area had been designed by the staff themselves. This showed the trust was involving staff in the development of the areas they worked in, which meant it was more likely to make facilities more appropriate and fit for purpose.

We discussed the low number of bathrooms / shower facilities with one of the midwives. She felt they used the two en-suite rooms first before using the other rooms for women in labour. The unit delivered approximately 1100 births a year (which is about three deliveries a day), there had not been any major issues with having one shower and one bathroom in addition to the two en-suite facilities as it was rare for the delivery suite to be full. There were additional toilets available on the delivery suite corridor.

We asked a member of staff about disabled access to the maternity unit. She said they had had disabled people on the maternity unit before and there had been no complaints or problems encountered. The unit is an older style building built on one level. Access to some toilet facilities was difficult for wheelchairs but facilities were available and we were told that staff would ensure that any disabled persons' needs were met.

We saw interesting, well presented patient information notice boards in all clinical areas. These included: photographs of all supervisors; boards explaining the purpose of supervision; posters outlining the work of the CQC; and an invitation from the trust for women to join the Midwifery Services Liaison Committee (MSLC).

We saw evidence from trust board minutes for September 2011 and December 2011 that showed discussions around proposed new build plans for maternity had taken place. We noted from those minutes and from being told by senior staff that discussions were ongoing between the hospital and the local commissioning groups, as to the shape of maternity services across Cumbria for the future, which might have an impact on the commissioning of any new build units. We also saw evidence of stakeholder involvement in the minutes of consultation with the Primary Care Trust and Local Authority Overview and Scrutiny Committees.

Our judgement
The trust was meeting this standard. People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.
Outcome 13: Staffing

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One woman told us, "I have never had any problem getting a member of staff when I need one."

Another said "There seem to be enough staff around when you need them. They couldn't be better."

Other evidence
We last inspected maternity services on 18 July 2011 when we found there were major concerns with staffing. We found there had been times when the labour ward at Royal Lancaster Infirmary (RLI) was full or staffing levels were low when women in labour had to be diverted to Furness General Hospital (FGH). The maternity risk management strategy and the escalation staffing policy were only in draft at the time of our inspection. When we looked at information supplied to us by the Trust, which showed how the trust calculated the levels of staff needed based on the number of deliveries per year, it appeared that RLI staffing levels were much lower than advised (2.18 whole time equivalent staff down) whereas FGH were only slightly below the required level.

We also saw that there was a risk to women due to unsatisfactory arrangements in staffing theatre rotas and the staff provision for dealing with emergencies. There was only one 'out of hours' team available 24 hours over seven days a week for theatres and no second emergency team if that team was already occupied in theatre. All specialities were covered by that one theatre team with no dedicated obstetric theatre team. We had been made aware of a serious untoward incident when obstetric cover...
had been compromised for a woman needing access to theatre but they were already dealing with an orthopaedic case. This had meant that the one theatre team had had to be split across two theatres.

We also found staffing issues over medical cover available for paediatrics on the maternity units due to unfilled posts. Although the trust was actively trying to recruit to paediatrics, paediatric consultants through goodwill had been ‘acting down’ to provide cover. This had increased their workload putting extra strain on their morale and risked breaching working time directives.

The trust wrote to us and told us they would introduce a second on call theatre team from September 2011. They would also finalise the midwifery staffing escalation plan and monitor its implementation, which would increase maternity staffing across RLI and FGH. The Trust later confirmed that newly appointed ‘band 5’ and ‘band 7’ midwives had been recruited across all sites and been supported by training and development packages.

At our unannounced visit on 14 August 2012 we saw staffing rosters, which showed two theatre teams were available out of hours and midwives and doctors told us that there had been two teams since September 2011. A doctor told us; “we have much better relationships with the anaesthetists now things are much improved.”

Another doctor told us “I feel there is still a need for a specialist obstetric anaesthetist as women are not able to get an epidural straight away if the anaesthetist is busy in theatre.” We spoke with the Deputy Head of Midwifery and Governance Lead (Deputy Head of Midwifery) and Director of Nursing about this and she told us that the unit did not have enough deliveries to warrant a dedicated obstetric anaesthetist but that one of the general anaesthetists had developed an interest in obstetrics and was working closely with the maternity unit to improve the service given to women.

We looked at staffing rosters and saw that staffing numbers on the maternity unit were now six in the mornings, six in the afternoons and five at night. Staff we spoke with confirmed these staffing levels.

Although new midwives at Agenda for Change ‘band 5’ and ‘band 7’ had been permanently employed to improve staffing levels, there was still a small amount of reliance on agency midwives to keep staffing levels at the right level. Agenda for Change is the current (NHS) grading and pay system for all NHS staff.

One midwife told us staff were worried once the trust had met all compliance actions and warning notices the use of agency staff would stop and they would be in a similar situation as before.

Another midwife told us that the impact of improved staffing levels was they were able to provide a good standard of care for women and have the time to access and attend mandatory and specialist training in a timely way.

We spoke with two senior managers who told us that both units were still using small numbers of agency staff because of covering for a small number of midwives who were on long term sickness or absence. Because of this they could not recruit permanently to those posts as those staff would eventually be returning to work.
We spoke with one agency midwife who told us that she was employed on a regular basis for a number of days in a row through an agency in London. Accommodation was provided by the trust. This was done to ensure there was as much continuity of care for women on the maternity units as possible. We were also told that the increased staffing levels, which had been put in since we visited last year were permanent and budgets for them had been agreed.

We spoke with one agency midwife who told us about her shift patterns, her induction to the unit and the mandatory training she had completed. She told us about incident reporting and the support she got from her colleagues.

We spoke with three medical staff working on paediatrics who told us there were now six paediatric consultants in post or about to start. These were all hospital based apart from one paediatric consultant who was to be based in the community. The medical staff told us that the trust had been unable to recruit middle grade paediatric doctors and so had employed consultant grades instead. Paediatric consultants would still have to 'act down' to provide cover as middle grades were not able to be recruited but there were now extra at consultant level to spread this out to achieve a work life balance.

A member of medical staff told us "everyone here has been 100% welcoming. Everyone's very approachable consultants, midwives everyone."

We looked at minutes from meetings for staff within 'bands 2/3, 5, 6, and 7'. The minutes showed that the following areas were discussed: staffing levels; proposed plans for new staff; changes in role; supervision; and organisational change. It was easy to see from the minutes staff had been able to give their views about a variety of things that were going on at the time. There still appeared to be some negative communication problems noted on the minutes but this showed that the minutes were a true reflection of the positive and negative feelings of staff members, and staff felt safe talking honestly to their managers. Two of the midwives told us one of the things they liked about the service now was that they valued being involved in planning for the future and helping turn the service round. They felt able to say what they felt without worrying about the consequences.

We saw minutes of the supervisors of midwives meetings for July 2012 where staffing issues, competency, use of clinical guidelines and the problem with the emergency buzzers were discussed.

**Our judgement**
The trust was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.
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

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>No patient views were received with regard to this outcome.</td>
</tr>
</tbody>
</table>

**Other evidence**
We last inspected maternity services on 18 July 2011 when we found there were major concerns with the reporting and escalation of risk. We had found that the risk registers were not always up to date and were not integral to the every day management of risk. At that time the risk register had not specifically identified the risks associated with only having one emergency team available out of hours and at weekends. In addition, although concerns around capacity and staffing levels had been entered into the register it had not been deemed a sufficient risk to be escalated higher than 'managed by the division' and consequently nothing had happened to improve the situation.

Although we had found that staff had reported incidents on the trust's electronic system and these were distributed widely to senior midwives, doctors and matrons to be reviewed by senior staff for any changes in practice to be identified, there was no formal mechanism for identifying who would review the incidents.

A review that the trust commissioned around its clinical governance arrangements (The Fielding Review finalised August 2010) identified areas for improvement that included changes needing to be made to the 'culture of team working'. A Rule 43 letter from the Coroner had also raised an ongoing concern about team working in the maternity services along with concerns in relation to record keeping, pressure of work and continuity of care. Following up on these issues we found inconsistent application of
guidelines and protocols where each site used different protocols, and trust wide
guidelines on the hospital intranet had not always been agreed and implemented within
the paediatric department. Throughout our inspection and when we spoke with external
agencies there had been a recognised problem that was repeatedly emphasised and
attributed to poor medical staff relations between Royal Lancaster Infirmary (RLI) and
Furness General Hospital (FGH).

Because we had major concerns with this outcome and taking into account the
concerns around other outcomes we served a warning notice on the trust on 31 August
2011 for Regulation 10 under The Health and Social Care Act 2008 (Regulated
Activities) Regulations 2010 (the Regulated Activities Regulations 2010) 'Assessing and
monitoring the quality of service provision.' This required the trust to be compliant with
the warning notice by 21 November 2011.

The trust wrote to us and told they were undertaking a review of all risk registers and
incident reporting. A multidisciplinary training workshop on risk management and
incident reporting was to be arranged for the division.

The trust were to review current clinical leadership arrangements. The Medical Director
and Associate Medical Director were to develop the clinical leadership structure within
the division. They were to develop an integrated and consistent approach to delivery of
care on all sites. Currently the trust was reviewing all maternity guidelines to improve
the safety of women and babies. Launch events for all guidelines to ensure they were
adopted and embedded were to be held from November 2011 to January 2012.

At our unannounced visit on 14 August 2012 we found that the provider had complied
with the details in the warning notice.

All midwifery staff and doctors we spoke with were able to describe when and how to
escalate risk via the online risk register. All explained that any grade of staff could
report risk and incidents and they would subsequently receive email feedback on the
progress of the incident report; this was appreciated as they felt their concerns were
now being taken seriously.

Use of the risk register was demonstrated to us and it was evident that the register was
being used to report incidents and risks, as well as 'near misses'. Clear audit trails of
actions and updated time frames were viewed and it was explained that all entries were
electronically notified to the Head of Midwifery (HoM), Consultant Obstetricians, the
Patient Safety and Risk Midwife and all Supervisors of Midwives (SoMs). The SoMs
stated that this mechanism provided an opportunity for them to consider 'lower level'
midwifery practice issues, as well as identify themes and trends with individual
midwives.

One midwife told us; "I have absolutely no hesitation when something is done to the
detriment of women, putting in an incident form." Another midwife said "Previously
there was no clear pathway (to report risk) but there is now."

We asked midwives about the cultural shaping workshops, which the trust had
introduced as part of mandatory training for all staff working within maternity to try to
improve relationships across all sites.
One midwife told us she had heard from colleagues that there was no management presence on the training days and she felt this would be detrimental to relationship building. When asked about this the Deputy Head of Midwifery and Governance Lead (Deputy Head of Midwifery) for maternity explained that a manager aimed to attend part of every session but the decision had been made not to attend the whole of the training session as they wanted staff to feel able to express their views without feeling constrained by senior staff presence.

We spoke with one of the doctors who told us he had yet to attend the cultural workshop but that he was scheduled to attend.

One midwife new to the trust explained that she had been made to feel very welcome by established staff. She felt able to share new ideas and to change practice and stated that staff were “willing for change, keen for change and wanted change to happen.” However, she went on to say; “the midwifery managers are pulling out all the stops, but not all the doctors. They seem to think it’s a midwifery issue and it’s not. They could lead so much, especially clinical guidelines, they may be doing it, but I’m not seeing it.”

Whilst acknowledging that the direction of travel of the organisation was positive, one midwife expressed a need for more prompt information when press coverage was anticipated “The trust falls short when things happen and there is going to be a press story. The senior team need to meet with staff to tell them, we shouldn’t be finding out in the paper, that shouldn't happen.”

One midwife told us “The regular email from the new Chief Executive (in post July 2012) was appreciated by staff however there was an unmet need to be acknowledged for the work we've done.”

Excellent examples of working together across all sites were noted. For example, we were told all emergency trolleys on both the FGH and RLI sites were now standardised, reducing the risk of rotational staff not being able to locate essential equipment in an acute situation.

Another example was given where the midwives at FGH, RLI and Helm Chase had already planned to meet up to share development ideas for a cross bay midwife led Vaginal Birth after Caesarean Section (VBAC) service. This midwife told us she had already been to work alongside her colleague at RLI with the aim of identifying similarities and differences in care provision.

We were told about another example of when cross bay working by the midwifery team had influenced a change in practice. A midwife explained that she had filled in an incident form for an issue related to the removal of an umbilical cord clamp. This incident form had been reviewed by a colleague from another site who questioned the usual practice at FGH. This resulted in a review of the evidence base and a subsequent practice change.

All midwifery staff and medical staff we spoke with were able to tell us where to find electronic versions of the clinical guidelines. They told us they were the same across all sites for obstetrics and anaesthetic departments and we were able to see this when we looked at three examples. The guidelines were clear and were supported by relevant references. Plans are currently in place to include the paediatric departments clinical
guidelines on to the same system. Where additional documentation was available to support the guidelines for instance a particular textbook, this had been identified by the library. One midwife told us she had been involved in reviewing a specific guideline and she explained how she involved other staff including medical staff in doing this.

Midwives and medical staff we spoke with told us they had weekly meetings to audit practice and discuss interesting cases and to review caesarean sections. On the notice board in the staff room we saw a copy of the 'Maternity & Paediatric Lessons Learned Newsletter' for July 2012. This detailed: feedback from clinical incidents and caesarean section / case review meetings; audit findings; and feedback from the 'Transforming Maternity Services Project', which focused on governance as well as paediatric services. It also contained examples of 'excellent care and service provision' and identified important documents for staff to keep up to date with. This newsletter was sent to all staff electronically as well as a hard copy being made available in staff rooms.

One doctor told us how she accessed clinical incident forms and clinical guidelines electronically and gave us an example of an incident she had entered onto the system. She was impressed that she "had received feedback on her report straight away."

We saw copies of the 'Matron's weekly safety walk round', where each Matron or 'Band 7' midwife did a spot audit in areas such as: record keeping; medicine charts; multidisciplinary team handover; early warning scoring; wearing of uniform and identification badge correctly; and cleanliness of the environment.

We were shown a presentation by the Deputy Head of Midwifery of the governance framework that had been developed for maternity services. This detailed the divisional governance structure, how information was captured, how it was fed up from staff to the clinical governance and quality committee, the hospital management team and the trust board and how staff on the ground received feedback. There is a Project Management Board in place across the trust which supports the departments work to monitor and improve governance and systems across the hospital.

Patient surveys had been sent out from April to August with 125 responses. Results were mixed with many positive and some negative issues detailed. We were told by the Deputy Head of Midwifery that negative comments were to be followed up and action taken to reduce any recurrence.

We were told about other ways that the service obtained views from its patients. These included: the maternity liaison committee, which had patients on the panel 'listen with mother'; the use of hand held audit machines, which could easily target specific issues; and suggestion boxes. The senior midwives were currently debating the use of face to face interviews with patients and how their regular walk rounds could be used in a more meaningful way.

The complaints process within maternity had recently been reviewed. A link person had been identified in the complaints department to work closely with the maternity unit. All complainants were given a choice of a face to face chat, a phone call or the option to use the normal formal complaints process. This seemed to be having positive results but as it had only just been started it was a little too early to tell how it would be received longer term.
Our judgement
The trust was meeting this standard. The provider had an effective system in place to regularly assess and monitor the quality of service that people receive.
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
The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak to patients about this outcome.

Other evidence
We last inspected maternity services on 18 July 2011 when we found moderate concerns around medical records not being stored securely within a locked room. The trust's responsibilities in relation to legislation around protecting confidential information, records management and information governance were not being managed correctly. We informed the trust that it was not meeting this standard.

The trust wrote to us and told us they would immediately place a keypad lock on the room containing the medical records and make arrangements to move the medical records to the correct storage facility. The trust also said it would ensure staff completed information governance training as part of the mandatory training programme, with additional on-line training being made available to support this.

At our unannounced visit on 14 August 2012 there were no records stored inappropriately within the maternity unit. The only medical records seen on the unit were records for women who were currently in-patients or who had been discharged that day. We saw record management policies were in place for the whole trust.

We examined two sets of medical records, which included looking at the prescription
charts. Both sets of records were up to date, completed accurately and prescription charts were correctly completed. We were told by a 'band 7' midwife that they had responsibility for auditing three sets of medical records each every month.

**Our judgement**
The trust was meeting this standard
Records were kept securely and staff were aware of their responsibilities in relation to current legal requirements and professional best practice.
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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. 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>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
</tr>
<tr>
<td>Further copies from</td>
<td>03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
</tr>
<tr>
<td>Copyright</td>
<td>Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.</td>
</tr>
</tbody>
</table>

Care Quality Commission

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>03000 616161</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
</tbody>
</table>
| Postal address   | Care Quality Commission  
|                  | Citygate  
|                  | Gallowgate  
|                  | Newcastle upon Tyne  
|                  | NE1 4PA       |