1. INTRODUCTION

1.1 This brief deals with a number of issues at the University Hospitals of Morecambe Bay NHS Foundation Trust and many of the questions which have been asked by the Cumbria Health and Wellbeing Committee ahead of the meeting on 12th December.

1.2 Although the Trust is currently facing some challenging issues, everyone who works in the organisation is committed to providing good quality and safe care across its hospitals. It is confident that it is providing good services and continues to receive very positive feedback from patients about the care they receive.

1.3 The recent issues include a report by the Care Quality Commission (CQC) following an inspection of maternity services; a formal intervention notice issued by Monitor; and problems with some outpatient follow-up appointments.

1.4 The Trust has made it clear that it is very concerned that these problems have occurred and a considerable amount of work has been done to address them. The brief sets out details about what actions the Trust has been taking and the continuing work it is carrying out to give patients confidence in the quality and safety of care provided in its hospitals.

1.5 The brief also considers the figures published by Dr Foster which suggest the Trust has a high mortality rate and press reports that ambulances have been queuing at the Royal Lancaster infirmary.

1.6 This brief also addresses, through the individual sections, many of the points raised in a recent article in The Westmorland Gazette by an alleged member of staff.

1.7 The Trust understands that this has been a difficult time for the people who work in the organisation. People obviously do not like to see negative stories about the place that they work and many people at every level in the Trust have been working particularly hard to make sure that the recent problems are dealt with quickly and effectively.
For example, in November Dr Peter Carter OBE, RCN Chief Executive and General Secretary, spent time with Emergency Department staff at the Royal Lancaster Infirmary, as well as visiting key medical wards. He said: “After speaking with the staff on the ward, there remains a high degree of job satisfaction and they told me that the hospital was a good place to work.

“There is no denying that the workload for the staff is very high but this does not affect the care the patients are given. I spoke to various patients on my visit and each one of them talked about the high standard of care they were receiving at the hospital. The most important thing has to be the high standard of care that patients tell us they are receiving and this should be celebrated.”

2. MATERNITY

2.1 Background

2.2 Four serious incidents occurred in 2008 at Furness General Hospital (FGH) Maternity Unit which required reporting to the Coroner.

2.3 Root Cause analyses were carried out on all incidents and a number of external reviews and internal audit investigations were carried out to provide the Trust with assurance that identified actions had been put in place.

2.4 However, in June 2011, following the inquest on one of the cases from 2008, the Coroner wrote a formal Rule 43 letter to the Trust. The police also announced that they were continuing with their formal investigation into a number of incidents at the Trust and UHMBT is cooperating with this fully.

2.5 It is important to note that no regulator has reported that the maternity services at UHMBT are unsafe.

3. CARE QUALITY COMMISSION

3.1 The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. They check all hospitals in England to ensure they are meeting government standards, and they share their findings with the public.

3.2 In July 2011, the CQC undertook a joint, three day unannounced inspection visit of all the Trust’s maternity units, together with the Nursing & Midwifery Council (NMC). Their report, published on the 9 September 2011, showed that the Trust was found to be ‘compliant’ in four of the ten standards assessed, with ‘major’ concerns in three and ‘moderate’ concerns in three.

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1 Rule 43: If the coroner feels that the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist, he/she may make a Rule 43 report which is sent to the organisation which has responsibility for the circumstances. A recipient of a Rule 43 report must send a written response within 56 days.
3.3 Following the Maternity Review in July 2011 and the publication in September 2011 of the report the CQC issued a Warning Notice to the Trust in respect of Regulation 10: Assessing and monitoring the quality of service provision.

3.4 In response to the formal Warning Notice, a major incident was declared by the local NHS commissioners in conjunction NHS North of England. Monitor’s report highlighted the need for the pace of change to be increased. The calling of a major incident is a device which enables skills, knowledge and resources in other parts of the NHS to be made available to help the Trust if required.

4. **ACTIONS TAKEN BY THE TRUST IN RELATION TO THE CQC REPORT**

4.1 A detailed action plan was developed to address the CQC’s concerns and assure compliance by 21 November 2011. All actions had an identified owner and executive lead to monitor day to day progress. Monitoring and evaluation continues by a whole health economy group where the SHA, PCT’s, and other stakeholders are represented. The Trust Board also report progress against plan formally, to an external panel where Monitor the CQC and health economy are represented.

4.2 Internally, monitoring evaluation and review is thorough. Divisional reporting is via relevant subcommittees to the Board. Reporting and monitoring is supported by electronic systems for risk, incident and national safety alerts. The systems allow for early warning triggers and detailed reporting of risks and incidents to provide assurance of compliance.

4.3 The Trust is confident that it has carried out all of the actions identified in the CQC review of its maternity services. All the relevant evidence was submitted to the CQC on 21 November 2011 and they will review the information before reporting back to the Trust.

4.4 Jackie Holt, Director of Nursing and Modernisation at UHMBT, said: “We are committed to providing a safe and high quality maternity service across our hospitals, so we were extremely concerned by the CQC’s findings. It isn’t acceptable and we have made significant improvements since then.”

4.5 The Trust has taken the following actions:

- **Out of hours emergency theatre staffing (major concern)**

  As the CQC pointed out, the Trust had already begun work on this issue earlier this year and a second ‘out of hours’ theatre team was put into place at FGH from 12 September 2011.

- **Respecting and involving people who use services / safety and suitability of premises (moderate concern / major concern)**

  The Trust accepts that the 26 year old premises at FGH need to be brought up to date and preparatory work has already begun on proposals for a major change to the maternity area, which could include a fully redesigned unit. This cannot be done overnight so in the meantime, it has implemented a system to
ensure that the corridors are cleared prior to any transfer. To ensure women are aware of this emergency transfer process, additional information leaflets have been produced to be given out on admission.

- **Cleanliness and infection control (moderate concern)**

  The open area identified was added to the cleaning rota immediately, as were the improvements to the CCTV housing. The fact that the single use strap used to monitor contractions was being re-used in some cases was addressed immediately and no longer occurs.

- **Records (moderate concern)**

  The CQC witnessed a high standard of record keeping across all hospitals. However, the storage of records in one particular area at FGH was not robust and unacceptable according to the Trust standard. The issue was immediately rectified.

- **Assessing and monitoring the quality of service provision (major concern)**

  The Trust has set up a cross bay forum so staff from all the appropriate disciplines across its hospitals are involved in discussing and agreeing guidelines and policies. This will help address issues with medical teams not working consistently across the hospitals. The maternity forum has already met a number of times.

  The CQC also criticised the Trust’s approach to risk management in that it was more reactive than proactive. The Trust recognises that this is an important issue. A number of workshops have been organised to remind staff about their roles and responsibilities in relation to risk management. There are also a number of work streams on-going to embed a culture of risk management from ward to Board.

  4.6 The Trust has made it clear that while it believes it has addressed all the actions set out by the CQC, it does not mean the improvement work is over. The Trust is now focusing on continuing to work with its partner organisations, the Maternity Liaison Group, mothers and staff to ensure it continues to make improvements to maternity services across the Trust and sustain them in the long term.

  4.7 The Trust has a plan in place to ensure that its women’s and children’s services continue to improve in the long term and this includes:

  - the development of a partnership relationship with Liverpool Women’s NHS Foundation Trust to provide mentorship, support and to further develop clinical leadership
  - giving our staff the opportunity to go and work within Liverpool Women’s NHS Foundation Trust to gain experience and knowledge in a specialist environment
• setting up a working relationship with a consultant midwife from the Imperial College Healthcare NHS Trust in London to provide us with guidance on practice and inter-disciplinary working and how we can enhance it
• working with an external midwife who specialises in practice development to help us with our future plans
• developing longer term plans to enable our midwives to rotate around our three maternity units to allow them to work with teams from across our hospitals
• developing stronger training and educational programmes for midwives, obstetricians and paediatricians
• developing a skills passport for staff which will not only allow us to identify any gaps in education or training but also to utilise any additional skills that we may not know they have, such as holistic therapies.

4.8 Whilst the CQC raised their concerns, they also reported the following:

The CQC Review of Compliance found that all the mothers talked with during the visit in July 2011 expressed satisfaction with the care and support they had received from midwives. Feedback from mothers included saying the staff had been “brilliant” and “acted quickly when things changed”, doctors and consultants had spent time with them and explained why changes to their plans were needed.

4.9 The CQC found that inter-professional teams were working well together at each of the hospitals and that that there were examples of good practice, such as informing and updating staff of changes following their reporting of issues and incidences.

4.10 The CQC reports acknowledges that the Trust’s midwifery and maternity services has systems in place to monitor and evaluate the delivery of care and practice.

4.11 Following the publication of the CQC report, the Trust quickly established a telephone line for concerned mothers, this service is still in operation. The phone line is in operation Monday to Friday 9am to 5pm (01539 715082).

5. NURSING AND MIDWIFERY COUNCIL (NMC)

5.1 In their report, the Nursing and Midwifery Council said ‘there are some clear challenges for University Hospitals of Morecambe Bay NHS Foundation Trust and the supervisors of midwives, however we were assured by the leadership and approach demonstrated by the newly appointed Head of Midwifery. Prior to the review, she had already identified and had planned to address key areas that we subsequently highlighted.'
5.2 They also commented:

- ‘Additionally the newly appointed local supervising authority midwifery officers have also already started to address issues and is committed to working collaboratively with the Supervisors of Midwives and senior members of University Hospitals of Morecambe Bay NHS Foundation Trust to strengthen and enhance the framework for supervision.

- ‘There are a number of effective initiatives taking place which supervisors are able to report verbally. However, these need to be documented and evidenced within the operating framework at a strategic level to ensure the safety and wellbeing of women using the maternity services.

- ‘The framework for statutory supervision needs to be much more visible both within University Hospitals of Morecambe Bay NHS Foundation Trust and for users of the service.

- ‘A strong clinical leadership is now apparent and there is clear support for statutory supervision from both the CEO and the director of nursing.’

5.3 The NMC made 19 recommendations. As these are largely consistent with the issues raised by the CQC, most of the actions taken in response to the CQC report also apply to the NMC report.

6. THE FIELDING REPORT

6.1 The Trust commissioned The Fielding report to look at all aspects of their maternity service because they wanted to make sure that they provided the safest possible care for mothers and babies.

6.2 This review of maternity services was commissioned by the Chief Executive with the support of the Trust board following five unconnected serious untoward incidents (SUIs) at Furness General Hospital (FGH) during 2008. It was not the purpose of the review to reinvestigate these incidents. Professional midwifery proceedings are still on-going with the Nursing and Midwifery Council. The trust and Local Supervisory Authority (LSA) investigations had already reported and this review was aimed at determining the direction of further improvement of the service.

6.3 Recently, the Trust has faced questions from the media as to the process for Foundation Trust authorisation in relation to the Fielding Report. The decision to authorise the Trust as a Foundation Trust (FT) was based on input from many different parties, including Monitor, the Care Quality Commission (CQC) and NHS North West.

6.4 Tony Halsall, Chief Executive says “Throughout our application, we were open and honest with all organisations regarding our services and our intentions for these services, including maternity.
6.5 "The CQC and NHS North West were made formally aware of our intention to carry out a review into the clinical governance arrangements of maternity services across our Trust and the terms of reference for the review in January 2010. Monitor were also made aware as part of our assessment to become an FT."

6.6 This report made many recommendations which the Trust have acted on including providing additional training for midwives and introducing new nationally recognised record keeping systems.

6.7 All of the recommendations were considered and assessed, however not all of them were suitable for implementation. An example of this was the suggestion of training of Maternity Support Workers to assist with the caesarean deliveries. This is because they are not professionally trained and would need to be to assist in caesarean deliveries. In addition, there would be issues round professional accountability and responsibility as they are not governed by a professional body.

7. **MONITOR**

7.1 Foundation Trusts are required, at all times, to remain compliant with their terms of authorisation. This includes ensuring that they meet the required standards in a number of targets and indicators as outlined in Monitor’s Compliance Framework.

7.2 As UHMBT has received a formal Warning Notice from the CQC this automatically triggered a review as to whether the Trust has breached its terms of authorisation. In October, Monitor confirmed that the Trust was in breach of terms of authorisation.

7.3 Monitor’s formal intervention notice required the Trust to:

   a. Appoint external advisors, to be agreed with Monitor, to undertake a full governance review, including quality governance.
   b. Accept the appointment by Monitor of external expert clinical advisors to undertake a diagnostic review of the Trust’s maternity services including their interface with paediatrics.

7.4 The Trust is working with Monitor to support and complete the process required by them which will provide further assurance that patient care will remain safe in the long term. The Trust is required, and will, work with the advisors to undertake any remedial work specified in action plans produced as a result of the reviews.

7.5 UHMBT expect to receive a report from Monitor on the diagnostic review of the Trust’s maternity services early in the New Year at the latest, and it will then ensure that their recommendations are implemented as quickly as possible.
7.6 The Governance review started in late November and a report is expected on this early in the New Year at the latest.

8. OUTPATIENTS

8.1 Background

8.2 There have been problems with the Trust’s outpatient appointment system which has resulted in some follow-up appointments having been delayed.

8.3 The Trust had been aware that there were some problems with the appointments system and had a team in place reviewing this since earlier in the year. However, in October 2011 it became clear that the problem was more significant than had originally been thought.

8.4 Actions taken by the Trust

8.5 The Trust immediately set up a 24 hour, seven day a week dedicated phone line (0845 608 0278) to allow any patients with concerns about their follow-up appointment to call and seek assistance. This service is still operation.

8.6 The Trust also established a team to ascertain the number and nature of appointments that may have been delayed and put in place additional clinics to allow patients to receive their appointment as soon as possible.

8.7 This review is being carried out by a dedicated project team including clinicians who undertake a clinical validation of the patient’s record to ascertain whether a follow-up appointment is required.

8.8 The team has:

a. Set up a monitoring database
b. Agreed a Standard Operating Procedure for the validation
c. Set up dedicated office space (to enable people to leave the usual work environment to focus on the exercise)
d. Identified Lorenzo ‘trainers’ to support validators
e. Identified a dedicated staffing resource that will be updated on a rolling basis
f. Initiated specialty level clinical validation—e.g. Dermatology review

8.9 The review aimed to identify the following:

a. If an appointment was required
b. If further clinical review was required
c. If a record needs to be removed from list (reasons for removal could include)
   • Duplicate record
   • Patient has had an appointment but booking process not correctly followed
   • Last clinic letter clearly states no further treatment required
   • Administrative record not closed appropriately
8.10 The review team identified 154 patients as priorities, and they had all been given appointments to see a clinician by 19 November. In addition the team identified 682 urgent cases and the patients concerned were given appointments to see a clinician by 3 December.

8.11 The Trust is aiming for all of the routine cases to be seen before the end of March 2012.

8.12 The Chief Executive has also appointed an external expert to carry out a thorough analysis of all the issues, including looking at all the factors that may have contributed to the problem, in order to understand the causes and to ensure the problems cannot occur again. Once their work has been completed a full report will be published.

8.13 Tony Halsall, Chief Executive of UHMBT, has said: “We are very sorry for the affect this has had on some of our patients. Everyone at the Trust is committed to providing a high quality service for our patients and we have been making every effort to deal with the problem as quickly as possible.

8.14 “I would like to thank our doctors, nurses and clerical staff, who have been working exceptionally hard to resolve this issue. This has involved reviewing patient records, arranging and staffing additional clinics and making direct contact with patients to ensure this all happens as quickly, and smoothly, as possible.”

9. MORTALITY

9.1 Background

9.2 Patient safety, quality of care and experience are UHMBT’s top priorities. Everyone in the Trust’s hospitals works hard to ensure it provides the best possible care for all its patients and to find new ways to make that care even better through its safety express and advancing quality programmes.

9.2 There are a number of different ways that figures for mortality rates are produced and these lead to different results. Mortality indicators such as Dr Foster and the Summary Hospital-level Mortality Indicator (SHMI) are extremely important indicators, to be used alongside other key data such as patient feedback and staff surveys.

9.3 A high mortality figure may reflect problems which may be explained by local circumstances or issues relating to data recording, coding or quality. Alternatively it may be a reflection of a real underlying problem in the quality of care that the hospital is delivering to its patients – and thus warrant further investigation.
9.4 However, although the fact that a hospital has a high figure does not necessarily mean that it has worse quality of care than a hospital with a low figure, the safety first approach means it is right to look at what lies behind the figures and see what they tell us about where improvements can be made.

10. **DR FOSTER**

10.1 One of the ways that hospital mortality rates are measured is the Dr Foster Hospital Standardised Mortality Ratio (HSMR) that is included in the annual hospital guide that they publish. The ratio measures deaths of adults whilst in hospital and excludes patients who were on palliative care pathways. To enable comparison each hospital’s score is compared against an average of 100.

10.1 At the end of November Dr Foster reported that UHMBT had one of the highest mortality rates in the country. The figures suggested that UHMBT’s Hospital Standardised Mortality Ratio (HSMR) has increased from 108 in 2009/10 to 124 in 2010/11.

10.2 The Trust was very concerned that the Dr Foster figures suggested there had been a significant increase in mortality rates. It has looked very carefully at the detailed information and has asked its doctors to continually review all deaths within the hospitals to ensure appropriate care was given in each case. The Trust also undertakes clinical audits to identify improvements in clinical care and provides staff with protected time for this.

10.3 The Trust is also a member of the North West Mortality Collaborative group and has invited the group to undertake a review of its processes in January 2012 as further assurance.

10.4 However, the Trust has actually seen a decrease in deaths at its hospitals from 1,997 four years ago to 1,634 last year (the year that the Dr Foster figures relate to). The Trust does not therefore believe it has an underlying issue with mortality.

10.5 It has identified there have been problems in the way some information has been recorded and that this is what resulted in the significant increase in the Dr Foster figures compared with the previous year. This has now been put right. The Trust has been working very closely with Dr Foster and they have reported that for the period April 2011 to August 2011 the Trust’s HSMR was 102.9.

11. **REPORTS OF AMBULANCE DELAYS AT THE ROYAL LANCASTER INFIRMARY**

11.1 In November the Westmorland Gazette published a story saying that ‘ambulances are waiting for up to five hours outside Royal Lancaster Infirmary’s accident and emergency department with patients on board’.
11.2 The paper quoted paramedic and ambulance union rep Paul Carlisle as saying that “It has been a problem which has been getting worse since UHMBT downgraded Westmorland General. It has got to a stage that we are waiting more than four hours which is dangerous.”

11.3 The Trust is aware that there have been some peaks in demand in the A&E department at Lancaster which have caused some delays in ambulance turnaround.

11.4 The Trust is working with other organisations to alleviate the pressure on the health system. One example of this is the North West Ambulance Service introducing a new pathway where patients will be triaged in a different way to enable more of them to be seen in the primary care assessment service at Westmorland General Hospital. The Trust is committed to working together on initiatives to ensure patients receive the highest quality of service on arrival at hospital.

11.5 However, it is rare, despite the current pressures, for any patient arriving by ambulance at the Royal Lancaster Infirmary A&E to wait three or four hours to be handed over from the ambulance crew. Patients do not wait in ambulances outside of the A&E department.

11.6 The decision to move services from Westmorland General Hospital was based on sound clinical judgment by hospital clinicians and local GPs. There was never a full blown A&E at Westmorland General Hospital with the essential backup services that there are at the Royal Lancaster Infirmary, such as intensive care. The Primary Care Assessment Services at Kendal still treats in the region of 20,000 patients a year.

11.7 In addition, the Trust, like many others throughout the North West, sees many patients who would be more appropriately and efficiently treated elsewhere, and is backing the Choose Well campaign. Choose Well reinforces the message that A&E and 999 services are for life-threatening and serious conditions. Local high-street pharmacies can help deal with minor illnesses and complaints such as coughs, colds, flu, stomach upsets, aches and sprains.

12. STAFF MORALE

12.1 The Trust is confident that all staff are committed and working hard not only to resolve the current issues, but also in providing a high quality service to their patients day in, day out. Undoubtedly staff morale will be impacted on; however they are all going about their jobs with upmost professionalism.

12.2 We have recently undertaken the NHS staff survey in our hospitals and we look forward to receiving the analysis shortly of their responses.
12.3 We will shortly be announcing a series of engagement activities with our staff, they will take place between January - March 2012 and allow every member of staff to have their say on how their hospitals are run.

12.4 In addition, we are developing more opportunities for staff to speak out and raise concerns, such as the promotion of our whistleblowing policy and also the recent launch of a confidential, anonymous phone line, where any member of staff, with concerns about the care, safety or the experience of any of patients can call. This service is operational 24x7x365.