

**Providing independent strategic clinical advice**

**Review of the response and  
planned actions by University  
Hospitals of Morecambe Bay  
NHS Foundation Trust (UHMBT)  
to RCOG Option 1**

**Written for  
Morecambe Bay Clinical Commissioning  
Group  
by  
Greater Manchester, Lancashire & South  
Cumbria Clinical Senate**

**20<sup>th</sup> November 2017**

## Chair's Foreword

Morecambe Bay Clinical Commissioning Group (CCG) commissioned Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate to undertake an independent review of the response to the Royal College of Obstetricians & Gynaecologists' Option 1 for the *Reconfiguration of Obstetric and Maternity Services in Cumbria 2014* by the provider, University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) for maternity services in the Morecambe Bay area.

From the paperwork received and the conversations held during the review visit, it is clear that an enormous amount of hard, and smart, work has taken place, and is still taking place to provide the best possible maternity services for the population of Morecambe Bay. The staff should be congratulated on this and the improvements for service users that are being reaped as a result. This is exemplified by a palpable quality and safety culture, which is apparent across the whole organisation. This is not isolated to maternity services.

The Trust and local system has had to balance the recommendations in RCOG option 1 with those from other reports and consider current and future requirements in the light of developments since 2014 when the report was published, including the recent establishment of Local Maternity Systems. The review panel concluded that this had been done skilfully and that there has been appropriate interpretation of Option 1 by UHMBFT. Where there is variation from the RCOG option 1, this has been well thought through and developed with stakeholders, giving due consideration to the risks and benefits of that variation.

I would like to thank the clinicians and managers in Morecambe Bay who have contributed to this review. Also my sincere thanks to the review team who provided their time and advice freely. I am grateful to members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice.

The clinical advice within this report is given in good faith and with the intention of supporting commissioners. This report sets out the methodology and findings of the review, and is presented with the offer of continued assistance should it be needed.



**Professor Donal O'Donoghue**  
**Senate Chair**  
**Greater Manchester, Lancashire & South Cumbria Senate**

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## 1. Introduction

- 1.1 The Royal College of Obstetricians and Gynaecologists (RCOG) options appraisal for the reconfiguration of obstetric and maternity services in Cumbria was commissioned by Cumbria CCG and Lancashire North CCG and published in March 2015<sup>1</sup>. Commissioners fully supported the findings of the recommendations of the report which included looking at the feasibility of implementing Option 1, i.e. to maintain two Consultant-led units (CLUs) with alongside Midwifery-led units (MLUs) in the Morecambe Bay area. The RCOG report fully acknowledged the very challenging geographical footprint of the services and the need to continue to provide local CLUs, as opposed to consolidation on a single site. The National Maternity Review<sup>2</sup> also highlighted the importance of local services in rural and remote areas.
- 1.2 In April 2017, Cumbria CCG ceased to exist and the South Cumbria area became part of Morecambe Bay CCG, along with the area previously covered by Lancashire North CCG. This CCG has commissioned Greater Manchester, Lancashire & South Cumbria Clinical Senate to undertake an independent review to examine the response by the provider, University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT), to RCOG Option 1 for maternity services in the Morecambe Bay area.
- 1.3 The review aims to:
  - 1.3.1 Identify whether the proposed model is credible and robust, taking into account the RCOG review findings, and highlight any areas of concern and make suggestions for improvement.
  - 1.3.2 Examine the clinical assumptions used regarding the feasibility and sustainability of maternity services across the Morecambe Bay area for the short term (up to 3 years -2020) and medium term (up to 7 years -2024).
  - 1.3.3 Advise on potential unintended consequences that should be taken into account.
  - 1.3.4 Advise on interdependencies that should be taken into account.
- 1.4 The Terms of Reference for the review include the following objectives:
  - 1.4.1 Have the clinical benefits, evidence for sustaining the current service model and underlying assumptions been clearly set out?
  - 1.4.2 Does the model reflect relevant clinical guidelines and best practice?
  - 1.4.3 Are the proposals sustainable for up to 7 years in terms of the clinical capacity to implement them?

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<sup>1</sup> [www.cumbriaccg.nhs.uk/about-us/2015-03-23--rcog-options-appraisal-final-report-\(nopword\).pdf](http://www.cumbriaccg.nhs.uk/about-us/2015-03-23--rcog-options-appraisal-final-report-(nopword).pdf)

<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

- 1.4.4 Do the plans identify mechanisms to address organisational and cultural challenges?
- 1.4.5 Has the workforce impact been considered with regard to:
- Education?
  - Recruitment?
  - Retention?
- 1.4.6 Have clinical staff that may be affected by the changes been involved in their development?
- 1.4.7 Is the proposed workforce adequate for the service needs, including being safe and resilient to staffing fluctuations?
- 1.4.8 Is the model able to deliver the current and future needs of the target population, based on population projections?
- 1.4.9 Do the proposals maintain access to services for the population? (E.g. have waiting times and travel for patients and their families been considered?)
- 1.4.10 Have the views and experiences of service users (patients and carers) been included in the model of care and design of plans?
- 1.4.11 Have innovations and improvements that would improve quality and outcomes been considered? (e.g. remote video)
- 1.4.12 Are there unintended consequences of the model that need to be taken into account?
- 1.4.13 Are there interdependencies in the model that have not been taken into account?
- 1.4.14 Have the risks and consequences of sustaining the model of care been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?
- 1.5 A copy of the full Terms of Reference is included as Appendix 1.

- 1.6 The Clinical Senate Review Team members were:

**Clinical Senate Review Chair:**

Professor Donal O'Donoghue, Consultant Renal Physician, Salford Royal NHS Foundation Trust

**Citizen Representative:**

Mel Gard, Chair, Maternity Services Liaison Committee, Bay Wide, Service User Representative

**Clinical Senate Review Team Members:**

Dr Mark Anderson, Consultant Paediatrician, Great North Children's Hospital, Newcastle upon Tyne

Dr Tony Kelly, NCD Maternity & Neonatal Improvement Collaborative, Kent Surrey Sussex AHSN (not in attendance at the visit)

Dr David Rowlands, Consultant Obstetrician & Gynaecologist, Wirral University Hospitals NHS FT

Judith Shaw, Midwifery & Nursing Quality, Audit & Research

Sue Townend, Consultant Midwife, Calderdale & Huddersfield NHS Foundation Trust

**Managerial and business support to the panel** was provided by the NW Clinical Senate management support team:

- Caroline Baines (Senate Manager)
- Daniel Baynham (Business Support)
- Becky Brown (Business Support)

## 2. Background

- 2.1 In March 2015, the Kirkup Report was published. This was an independent investigation into serious failings in maternity services at UHMBT. As well as documenting what went wrong and why, it set out the improvements needed to ensure a safe and high quality service was provided in future to the women and children of the Morecambe Bay area.
- 2.2 At a similar time, the RCOG published their review, which was commissioned by the CCGs, and provided an options appraisal for the reconfiguration of obstetric and maternity services across Cumbria and North Lancashire. Whilst some of this work ran parallel to the Kirkup Report, the Terms of Reference for the two pieces of work were different and the RCOG team were not privy to the findings or conclusions of the Kirkup Report until it was published.
- 2.3 The recommended option from the RCOG review was Option 1: To maintain two Consultant-led units (CLUs) with alongside Midwifery-led units (MLUs) in the Morecambe Bay area.
- 2.4 The geographical area is generally rural and sparsely populated, with a small number of more densely populated urban centres. There are pockets of significant deprivation and child poverty, and the transport infra-structure is poor compared to other parts of the country. This geography poses a specific challenge in terms of providing services that are both convenient to service users and which meet safe clinical standards.
- 2.5 It is important to note that this review examines services in the Morecambe Bay area of South Cumbria and North Lancashire only. Services for the rest of Cumbria have been considered in a separate piece of work.

### **3. Methodology**

- 3.1 A number of teleconferences and meetings took place between the Clinical Senate, Commissioner and Provider in the period from February 2017 to May 2017 to develop and agree the Terms of Reference for the review (Appendix 1).
- 3.2 Once the Terms of Reference were agreed, there were a number of calls between May and August 2017 between the Clinical Senate, Commissioner and Provider to ensure the information required by the review panel was made available.
- 3.3 The review panel visited the Morecambe Bay area on the 10<sup>th</sup> and 11<sup>th</sup> October 2017 (see Appendix 2 for full itinerary). The panel travelled to Furness General Hospital and Royal Lancaster Hospital to see the facilities, meet key staff and gain an appreciation of the challenge(s) posed by the local geography and infrastructure. The panel met with CCG and UHMBFT representatives at the end of the visit and fed back their initial thoughts.
- 3.4 A draft report was sent to commissioners for accuracy checks on 2<sup>nd</sup> November 2017 with feedback received by 10<sup>th</sup> November 2017. The final report was ratified at the GMLSC Senate Council on 17<sup>th</sup> November 2017 and sent to Morecambe Bay CCG on 20<sup>th</sup> November 2017.

## **4. Issues/Views expressed during review**

This section is intended to highlight significant issues/views expressed during the review. It is not intended to give an extensive record of the wide ranging and very helpful discussions which took place in each of the planned sessions. Further discussion of the panel's response to these views is contained within Section 5.

### **4.1 Key Issues/Views – Morecambe Bay CCG**

Morecambe Bay CCG commissioned this review as it was keen to gain independent clinical advice as to whether the proposed model for maternity services within the area is safe and robust. The CCG's requirements are captured with the aims and objectives of the review (as detailed in Sections 1.3 and 1.4). It was apparent that there has been a considerable amount of close working between commissioners and the Trust, and this is to be congratulated.

### **4.2 Key Issues/Views – UHMBFT**

#### **4.2.1 Trainees**

The views expressed by all trainees were of an excellent training experience across specialties other than obstetrics at FGH. This lower satisfaction was not due to the quality of training, which was still very high, but due to the low number of births within the unit which limited the exposure of trainees' experiences.

Trainees were candid about UHMBFT not necessarily being one of their preferred options. However, all reported that they were very much enjoying and valuing their time there, and recognising that they are generally getting excellent training. This is demonstrated by the high retention rates.

#### **4.2.2 Clinical Teams**

Clinical leads view the obstetric service as one unit operating across the two acute sites, FGH and RLI. There are a number of working practices in place to facilitate this including daily video calls, joint training and single operating policies and practices. Midwifery ensure cross-Bay working, in part by all band 5 staff undergo a two-year rotation across sites and areas, whilst also providing cover as required.

There is a young consultant workforce, many of whom have been recruited on the basis of their working ethos and culture as well as their skills. This has brought in enthusiastic staff wanting to be a part of the new way of working within UHMBFT and to contribute towards embedding and sustaining it. Recruitment is, however, still a challenge across a number of specialties, and the Trust has had to work hard to attract staff due to the geography of the area. This has reaped mixed rewards with recent successful recruitment of consultants in anaesthesia and emergency

medicine. Staffing pressures remain in paediatrics and middle grades in particular, but these are national issues and not just local.

The quality of training has improved significantly at UHMBFT, recognised by both the General Medical Council (who has given O&G training an 'excellent' rating) and the Royal College of Obstetricians and Gynaecologists who place them in the top 10% nationally for professional development.

Multiagency working between the hospital, community and primary care has improved thus ensuring that community and primary care colleagues are increasingly equipped with the knowledge and skills to manage pre-existing disease in pregnant women, and regarding appropriate escalation to secondary care.

### 4.2.3 Midwifery

It was very apparent that the Midwifery service has come a long way from one that was fearful post-Kirkup report to one that is confident to freely and safely practice the art of midwifery. This is supported by the number of complaints being down, improvements in incident reporting and consistently high Friends & Family scores. Indeed "*the enthusiasm of the midwives was palpable*". There was great pride and enthusiasm in their work, which was particularly apparent when discussing the Safe Active Births (SAB) work where very high service user and partner feedback has been received due to the level of support and personalisation received.

Midwives reported that working relationships have improved across the board and that there are excellent working relationships with consultants, demonstrated by mutual respect and healthy challenge. This has been particularly so in Barrow and been aided through SAB and working with the Maternity Liaison Services Committee, to ensure that women are at the heart of the service. There is a clear appetite to roll out the SAB way of working to all midwives so that this becomes the normal way of working. Midwives report that this way of working is spreading throughout the community also, with pregnant women reporting that they are buying aromatherapy oils ready for labour, after hearing about it from women who have been supported by a SAB midwife.

The choice of three sites for delivery is highly beneficial to service user choice and this has been increased by changes in the sites working closer together.

There is a clear enthusiasm for case-loading midwifery if the required additional resource could be secured with which to undertake the necessary pilots. Other improvements in the service would be possible through innovations which have been considered and in part, implemented.

Remote video-calls between FGH and RLI are an excellent example where technology has been implemented to positive effect. However, lack of resource has meant that other identified improvements have not been implemented. This includes community midwifery staff not having access to remote recording devices with 3G / 4G capability for data collection, mobile scanning equipment or bilirubinometers.

#### 4.2.4 Executive Team

Trust Executive Team members clearly articulated the context within which this review takes place: Staff have been through a difficult few years following the well-documented historical issues. The leadership team have exemplified “holding the mirror up” to themselves and making improvements.

It was highlighted that it has never been stated that there was a lack of technical skills in the UHMBFT clinical staff: the issues were due to a lack of willingness to learn from mistakes and poor communication, both with patients and between colleagues.

An enormous amount of work has been undertaken to improve governance, service user involvement, culture, staffing and training, and this is showing significant benefits, as evidenced by a sustained increase in patient satisfaction and the settling of local unrest.

There is a clear joined-up governance system in place across the Trust’s sites with single operation policies and procedures. This has resulted in improved cross-site working.

As with most NHS organisations, UHMBFT face challenges regarding finance and staffing, but welcomed ideas about how the same standard, or improved standard, of service could be delivered within the same financial envelope.

## 5 Discussion

The sub-sections below contain analysis and discussion relating to the objectives described in the introduction and in the Terms of Reference (Appendix 1).

### 5.1 Have the clinical benefits, evidence for sustaining the current service model and underlying assumptions been clearly set out?

The clinical benefit of maintaining consultant-led units on both the Furness General Hospital (FGH) and Royal Lancaster Infirmary (RLI) sites is clearly articulated with regards to the geographical challenge, deprivation and complexity of the area. The midwifery and senior clinical staffing model is particularly strong as is the cross-site working model.

Similarly the risks associated with the challenging geography are strongly articulated. However, mitigation of those risks is not so strongly expressed and the panel's view is that there could be more creative ways of achieving the required mitigation whilst addressing other key issues and risks. These include the poor obstetric experience for O&G trainees in FGH. It is important to stress at this point that the experience is classed as "poor" solely due to the low numbers of births and not due to the quality of training itself which has improved dramatically in recent years. The quality of gynaecology training is excellent.

One solution that the panel recommends is to consider O&G trainees from FGH providing residency night cover at RLI. This would both improve the numbers of births they are exposed to and help to address issues regarding lack of middle grade cover.

Additionally, the panel recommends that the Trust considers moving elective caesarean sections for placenta praevia from FGH to RLI to mitigate potential risks and complications, due to the proximity of tertiary services (such as vascular services at Preston) which is at least an hour closer to the RLI site than the FGH site. The panel wish to stress that this recommendation is in no way a reflection on the standard of care at FGH, which they recognise to be just as good as that at RLI. It is merely a reflection of the challenging geography and the difference that an hour or more transfer may make to the outcomes for some women and babies in some clinical situations.

However, the panel recognises that FGH are acutely aware of the significance of geography in situations which may necessitate transfer and are frequently making those decisions on a case by case basis.

The articulation of how the Trust intends to maintain a three-tier model at FGH is not well articulated and the panel feel that the underlying assumptions regarding the sustainability of this model have not been tested as rigorously as they need to be. This is particularly given the declining numbers of middle grade staff nationally. As previously mentioned, the Trust has successfully improved training with high retention. However, it has not been explicitly stated

how the Trust will use this success, and the recognition it has achieved as a result, to ensure that UHMBFT is seen as an attractive placement and one that junior doctors are keen to stay at throughout their careers.

There are vulnerabilities in the paediatrics service staffing which cause uncertainty regarding the sustainability of the model in this area. However, the panel recognise that this is a national issue, and not just a local one. They also think that the organisation has done everything it could reasonably be expected to do to manage this situation through recruitment drives and workarounds, with some reasonable success. The panel recommends that long-term thought and planning is required regarding the sustainability of a two-tier paediatrics model at FGH, particularly regarding recruitment and the challenging geography. The panel does not support the proposal in the response document to have a Paediatric Consultant rota at FGH without junior grade staff.

There is a keen appetite for the introduction of two case-loading midwifery pilots in the area to identify which model(s) might be best suited to different populations and geographies, in order to improve service experience and outcomes for women and babies. Sadly, the funding bid for this was unsuccessful and it is not safe or appropriate to proceed without this additional resource. Midwifery staff have been undeterred, however, and have creatively addressed some of the issues within existing resource including a two-year rotation for all midwifery staff between settings and locations.

## **5.2 Does the model reflect relevant clinical guidelines and best practice?**

The model reflects clinical guidelines and best practice and there is clear evidence of cross-site agreement regarding working practices.

The panel's initial response was that the pre-visit documentation was somewhat lacking evidence of this. However, conversations during the visit more than assured them of this and they are pleased to see the receptiveness to new ideas and recommendations such as moving elective caesarean sections for placenta praevia from FGH to RLI (described in Section 5.1).

There is a higher level of category 1 caesarean sections undertaken with general anaesthetic at FGH than at RLI. The panel recommends a case by case audit of these to identify whether there is any learning that could be put in place to reduce this proportion in the future, possibly through earlier intervention.

The panel recommends that data for the Strategic Clinical Network's Maternity Dashboard is provided by site rather than by organisation. This will provide assurance to the CCG and the wider system that standards are being met on both sites.

### 5.3 Are the proposals sustainable for up to 7 years in terms of the clinical capacity to implement them?

It is difficult to project seven years forward for any aspect of care in the NHS, and this is no exception. The main risk to sustainability over the next seven years will be the workforce. There will certainly be challenges for paediatrics, middle grade doctors and O&G.

However, there is a young consultant workforce, who are committed to the new approach of UHMBFT and who want to be a part of its success. Recruitment procedures have been tailored to ensure that successful candidates share the organisational ethos, which is likely to bring increased staff retention and increase sustainability.

The panel recommends that to improve sustainability, UHMBFT considers a more integrated service, i.e. one service operating over two sites, rather than two separate services. It is recognised that there are difficulties with cross-site cover and the panel therefore recommends that the Trust considers Consultant-Led services with two tiers at FGH and three tiers at RLI, using existing staff as resident consultants to cover FGH and middle grade / trust grade staff to provide cover at RLI. This model would require staff to be classified as UHMBFT staff and not RLI or FGH staff. It is recognised that this is not a popular proposal amongst all staff but the panel believe it to be a necessity if both units are to be sustainable. This model is likely to spread nationally due to the decreasing numbers of middle grades and members of the panel themselves are expecting to be working in this way in the near future. Therefore it is their recommendation that this is explored further.

Similarly, further exploration is required of the approach to middle grade staff as this is currently not demonstrating any evidence of being sustainable, particularly at FGH where the current workload is not enough to justify the staffing levels (at times there are more doctors than women in labour in the unit which is a near unique, if not completely unique, situation). Furthermore, the panel could not identify any evidence of any effective planning regarding how to address this. It is recommended that the recommendations discussed in Section 5.1 regarding this matter are therefore actioned accordingly.

The aforementioned issues regarding paediatric recruitment, as described in Section 5.1, are an additional cause for concern over the next seven years.

From a midwifery perspective, workforce issues appear to have been well thought through with consideration of possible changes to the delivery model, should resources become available. In particular, case-loading midwifery to improve continuity of care: If this to be piloted, additional midwifery staff will be required.

#### 5.4 Do the plans identify mechanisms to address organisational and cultural challenges?

The organisational and cultural challenges have been very well addressed. The panel's view is that although this was not clearly expressed in the pre-visit reading, the conversations that took place during the visit provided clear evidence. The panel are extremely impressed with the work that has, and still is, taking place.

It is clear that staff, in particular Midwifery staff, have addressed these challenges and there is clearly great pride in the care they deliver. Strong leadership is evident and this has fostered a culture where staff are supported and feel empowered.

Amongst medical colleagues, traditional working patterns and hierarchical thinking seems to have somewhat inhibited the same degree of change experienced within midwifery. Some flexibility of thinking is required for doctors to be able to do the same, particularly with regard to working patterns and locations.

An area identified as lacking in consistency was regarding the daily video calls between labour wards. Staff at RLI value these calls and feel that they “set up their day” whereas some at FGH see it as a “checkbox exercise”. The panel recommend that the two sites openly share and discuss their differing perspectives to ensure that these calls are seen as high value across both sites. It is also recommended that the calls take place twice a day, such as at 09:00 and 17:00 or 09:00 and 21:00.

A comment was made by one colleague at RLI that “things are done differently in Barrow”. In some instances, the ‘difference’ is a valid positive and creative response to different circumstances / practical considerations, rather than an ‘attitude’. It is certainly not due to an inconsistency in governance, clinical standards and cultural ethos.

The panel recommends that any differences are overtly identified, discussed and audited. For example, higher levels of general anaesthetic category one caesarean sections at FGH, as discussed in Section 5.2.

More positively, it is apparent that colleagues value the joint audits and joint perinatal meetings, and there is clear evidence of joint working protocols and governance. The panel recommend that the trust develops “before” and “after” scenarios regarding the organisational and cultural changes to help demonstrate and evidence the success of this work, which was readily, consistently and openly referenced and discussed by a broad cross-section of colleagues within the trust. These scenarios, along with the existing documentation on measuring cultural and organisational change, should be included in any future paperwork or submission to the CCG and NHS England as evidence of this excellent work.

The panel recommends that UHMBFT share their work and learning on organisational and cultural change, as an example of best practice, with other organisations.

### **5.5 Has the workforce impact been considered with regard to education, recruitment and retention?**

The panel is satisfied that a lot of effort has gone into recruitment and retention. There have been mixed successes by discipline, but the range and extent of effort must be recognised and congratulated.

The Trust provides excellent educational opportunities, which are well-regarded by trainees. The trust has recently received recognition from the Royal College of Obstetricians and Gynaecologists regarding its professional development by being placed in the national top 10%.

The joint PROMPT (Practical Obstetric Multi-Professional Training) training across both sites is one example of excellent practice. The only exception to this excellence is the obstetric training at FGH as discussed in Section 5.1.

Similarly the two-yearly midwifery rotation is an excellent example of the Trust's commitment to continuing professional development and training.

Midwifery leadership is very strong, encourages new ideas and supports trials of new ways of working within acceptable parameters of safety and quality. This leadership in turn has fostered a workforce which is empowered, enthusiastic and receptive to new ideas. This is evidenced by the Trust leading the field nationally in the development of the Safe Active Births (SAB) Midwifery role through the appointment of SAB Midwives. It is clear that there is an excellent understanding of what "midwifery-led" care means within the organisation.

### **5.6 Have the clinical staff that may be affected by the changes been involved in their development?**

The panel is absolutely satisfied that affected clinical staff are fully involved in any changes and that there are opportunities for open discussions of such matters. The panel recommends that some medical staff may need more support and encouragement to trial new ways of working.

### **5.7 Is the proposed workforce adequate for the service needs, including being safe and resilient to staffing fluctuations?**

The proposed workforce is resilient other than the previously described issues regarding:

- Staffing levels at FGH outweighing the need, which has an impact upon both the quality of trainees' obstetric experience and the sustainability of the service in the future.
- Paediatric and middle grade recruitment concerns.
- The need for more midwifery staff to allow case-loading pilots to take place.

Please see Sections 5.1 and 5.3 for more detail.

## **5.8 Is the model able to deliver the current and future needs of the target population, based on population projections?**

Population projections have clearly been considered in the model and the panel is satisfied that the Trust has listened to local need and responded appropriately. However, the panel recommends that evidence-based modelling and an objective analysis of risk is undertaken as plans appear to be based largely on the basis of local population feedback with little consideration for these other factors.

As per Section 9.3 of the RCOG Report (2014), social deprivation is the main variable that affects maternity outcomes. The population served by FGH has considerable levels of social deprivation and the proposed model goes some way to achieving the required balance between safe services and local services. However, more creative thinking regarding this, as described in Section 5.1, could help to improve this, particularly with respect to high risk transfers and distance to tertiary centres.

As previously described, the assurance the panel could give regarding this would be even greater if the Trust operated a single obstetric service across FGH and RLI. This would help to maintain the high quality of the service in this unique geography whilst making best use of resources. The Midwifery Service appears to have achieved this successfully, and the panel recommends that learning is shared.

## **5.9 Do the proposals maintain access to services for the population? (E.g. have waiting times and travel for patients and their families been considered?)**

It is well-evidenced that the proposals maintain access to services for the local population, and clear that waiting and travel times for patients and families have been influential in their development.

## **5.10 Have service users (patients and carers) views and experiences been included in the model of care and design of plans?**

It is well-evidenced that service users' views and experiences have been included in the model of care and plans, and that this is paramount to the Trust, clearly forming part of their new culture and organisational ethos. There are excellent working relationships between service user representatives and the Trust, and service user feedback supports the great pride that staff rightly have regarding the care they deliver.

The panel recognises the achievements of good practice in service user engagement in working with the Bay Wide Maternity Services Liaison Committee (MSLC). The panel recommends that there is continued financial support from commissioners and multi-disciplinary team (MDT) involvement from individuals within the Trust to establish the successful function of the new Maternity Voices Partnership (MVP) as the main forum for partnership working. This will build on previous positive relationships and will foster increased involvement from a diverse range of service users in Morecambe Bay. It also includes encouraging links with the other MVPs in the Local Maternity System to share best practice and ideas.

### **5.11 Have innovations and improvements that would improve quality and outcomes been considered? (E.g. remote video)**

Innovations and improvements have been considered and in part, implemented. Remote video-calls between FGH and RLI are an excellent example of this. However, lack of resource has meant that other identified improvements have not been implemented. The panel recommends that commissioners and Trust colleagues work together to identify resource to allow for implementation of the following within the community midwifery team:

- Remote recording devices for data collection
- Scanning equipment
- Bilirubinometers

The panel supports the case made that the above would offer a plethora of benefits, including:

- Improved quality of care
- Improved service user experience
- Improved efficiency of the service by not having to wait for test results to travel from home to hospital and back again
- Reduce unnecessary admissions / readmissions
- Improve the reliability and completeness of data recording
- Improved cross-bay working
- Financial savings.

### **5.12 Are there unintended consequences of the model that need to be taken into account?**

A positive unintended consequence of the model is that a safety culture, originally fostered in obstetrics, has spread across the organisation and is improving standards across the board.

There is the potential that the new Maternity Unit at FGH could attract service users from outside of the existing catchment area, such as Millom, and increase the number of births taking place each year. The new unit can easily accommodate such an increase both in terms of infrastructure and staffing and would improve the exposure to births experienced by the O&G trainees at FGH.

The Trust needs to ensure that the Helme Chase Midwifery-Led Unit continues to offer a high quality experience to service users and that it communicates effectively to the public regarding their choices across the three sites.

If the model recommended in this report is adopted then the Trust would need to ensure that O&G trainees from FGH do their gynaecological work at FGH and provide obstetric on-call at RLI. This will provide a more sustainable staffing model.

### **5.13 Are there interdependencies in the model that have not been taken into account?**

It is clear that interdependencies with key disciplines, including anaesthetics, paediatrics, ambulance, primary care and community service have all been taken into account in the development of the model. However there are some risks and issues that need addressing. The panel recommends that further consideration is given regarding the interdependencies with tertiary care and the transfer times from each site, such as transferring elective caesarean sections for women with placenta praevia to RLI, as discussed in Section 5.1.

The panel recommends that the Trust liaises with Health Education England North West to ensure that their training numbers are maintained regardless of any change in configuration of staffing across FGH and RLI.

### **5.14 Have the risks and consequences of sustaining the model of care been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?**

The panel is satisfied that the risks have been identified and generally there have been reasonable mitigating actions put in place.

The risks associated with the model are held in departmental and organisational risk registers. The panel is not convinced that the Trust have fully considered the risks and required mitigations associated with future implementation and sustainability of the model. This was particularly apparent

regarding the sustainability of middle grade staff, variations in category one caesarean section rates with general anaesthetic and transfer times to tertiary care as mentioned previously in this report. The panel recommends that due consideration is given to these areas in particular.

## **6. Conclusions and Recommendations**

- 6.1 The panel thoroughly enjoyed this piece of work and were left impressed and inspired by the standard of care, improvements made, cultural changes achieved, as well as the palpable enthusiasm and desire of the staff to provide the best possible service for local women.
- 6.2 The panel makes the following recommendations (overleaf), which are intended to be supportive and constructive:

## Review Panel Recommendations

- 1) UHMBFT should consider more creative solutions to mitigate the risks of the challenging geography. For example, O&G trainees from FGH to provide residency night cover at RLI.
- 2) Due to the proximity of tertiary services, UHMBFT should consider moving elective caesarean sections for placenta praevia from FGH to RLI to mitigate potential risks and complications.
- 3) Long-term planning is required regarding sustainable two-tier paediatrics service at FGH, particularly regarding recruitment and the challenging geography. A consultant-only service is not supported.
- 4) UHMBFT should undertake a case by case audit of category 1 caesarean sections at FGH undertaken with general anaesthetic to identify any learning that could be implemented to reduce the proportion and bring performance in line with that at RLI.
- 5) Data for the SCN's Maternity Dashboard should be provided by site rather than by organisation. This will provide assurance that standards are being met on both sites.
- 6) To improve sustainability UHMBFT should operate a more integrated service, i.e. one service operating over two sites, rather than two separate services. Learning from Midwifery should be applied.
- 7) UHMBFT should consider Consultant-Led O&G services with two tiers at FGH and three tiers at RLI, using existing staff (from RLI and FGH who currently do resident cover) as resident consultants to cover FGH and middle grade / trust grade staff to provide cover at RLI.
- 8) FGH and RLI should openly share and discuss differing perspectives regarding daily video calls to ensure the value is recognised across both sites. It is also recommended that consideration is given to the calls taking place twice a day. E.g. At 09:00&17:00 or 09:00&21:00.
- 9) Any differences between FGH and RLI are overtly identified, discussed and audited. E.g. The difference in category 1 caesarean section general anaesthetic rates.
- 10) UHMBFT should develop "before" and "after" scenarios regarding organisational and cultural changes to help demonstrate and evidence the success of this work. These scenarios, along with existing documentation on measuring cultural and organisational change, should be included in any future paperwork or submission to the CCG and NHS England as evidence of this excellent work.
- 11) UHMBFT should share their work and learning on organisational and cultural change, as an example of best practice, with other organisations.
- 12) Evidence-based modelling of plans and an objective analysis of risk should be undertaken to complement the excellent work done to date involving local population feedback.
- 13) There should be continued financial support from commissioners and MDT involvement from individuals within the trust to establish and maintain the successful functioning of the Maternity Voices Partnership as the main forum for partnership working.
- 14) Commissioners and Trust colleagues should work together to identify resource to allow implementation of the following within the community midwifery team:
  - Remote recording devices for data collection
  - Scanning equipment
  - Bilirubinometers

# Appendices

## Appendix 1 - Terms of Reference

### Independent Clinical Review: TERMS OF REFERENCE

#### 1. STAKEHOLDERS

**Title:**

Review of the response and planned actions by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) to RCOG Option 1

**Sponsoring Commissioning Organisation:**

Morecambe Bay CCG (from 1/4/17 - previously Lancashire North CCG)

**Lead Clinical Senate:**

Greater Manchester, Lancashire & South Cumbria

**Terms of reference agreed by:**

- Donal O'Donoghue (Senate Chair)
- Caroline Baines (Senate Manager)
- Julia Westaway (Commissioning Lead from Sponsor)
- Andrew Bennett (CCG Chief Officer)

**Date:** May 2017

**Clinical Senate Review Chair:**

Professor Donal O'Donoghue, Consultant Renal Physician, Salford Royal NHS Foundation Trust

**Citizen Representatives:**

Mel Gard, Chair, Maternity Services Liaison Committee, Bay Wide, Service User Representative

**Clinical Senate Review Team Members:**

Dr Mark Anderson, Consultant Paediatrician, Great North Children's Hospital, Newcastle upon Tyne

Dr David Rowlands, Consultant Obstetrician & Gynaecologist, Wirral University Hospitals NHS FT

Judith Shaw, Midwifery & Nursing Quality, Audit & Research

Dr Tony Kelly, NCD Maternity & Neonatal Improvement Collaborative, Kent Surrey Sussex AHSN

Sue Townend, Consultant Midwife, Calderdale & Huddersfield NHS Foundation Trust

#### 2. QUESTION & METHODOLOGY

**Background Information**

The RCOG review into maternity services commissioned by Cumbria CCG and Lancashire North CCG was published in March 2015<sup>3</sup> in response to the Kirkup review. Commissioners fully supported the findings of the recommendations of the report which included looking at the feasibility of implementing Option 1 which was to maintain 2 Consultant-led units (CLUs) with alongside Midwifery-led units (MLUs) in the Morecambe Bay area. The RCOG review fully acknowledged the very challenging geographical footprint of the services and the need

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<sup>3</sup> [www.cumbriaccg.nhs.uk/about-us/2015-03-23--rcog-options-appraisal-final-report-\(nopword\).pdf](http://www.cumbriaccg.nhs.uk/about-us/2015-03-23--rcog-options-appraisal-final-report-(nopword).pdf)

to continue to provide local CLUs. The National Maternity Review also highlighted the importance of local services in rural and remote areas.

The CCGs (to be Morecambe Bay CCG from 1/4/17) now request the clinical senate undertake a desk top review to consider the submission from UHMBT and advise accordingly.

**Aims and Objectives of the review:**

The aim of this review is to examine the response by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) to RCOG option 1 for maternity services in the Morecambe Bay area. In particular:

1. To identify whether the proposed model is credible and robust, taking into account the RCOG review findings, and highlight any areas of concern and make suggestions for improvement.
2. To examine the clinical assumptions used when regarding the feasibility and sustainability of maternity services across the Morecambe Bay area for the short term (up to 3 years -2020) and medium term (up to 7 years -2024).
3. To advise on potential unintended consequences that should be taken into account.
4. To advise on interdependencies that should be taken into account.

The objectives of the review are to assess:

1. Have the clinical benefits, evidence for sustaining the current service model and underlying assumptions been clearly set out?
2. Does the model reflect relevant clinical guidelines and best practice?
3. Are the proposals sustainable for up to 7 years in terms of the clinical capacity to implement them?
4. Do the plans identify mechanisms to address organisational and cultural challenges?
5. Has the workforce impact been considered with regard to:
  - a. Education
  - b. Recruitment
  - c. Retention?
6. Have the clinical staff that may be affected by the changes been involved in their development?
7. Is the proposed workforce adequate for the service needs, including being safe and resilient to staffing fluctuations?
8. Is the model able to deliver the current and future needs of the target population, based on population projections?
9. Do the proposals maintain access to services for the population? (E.g. have waiting times and travel for patients and their families been considered?)

10. Have service users (patients and carers) views and experiences been included in the model of care and design of plans?
11. Have innovations and improvements that would improve quality and outcomes been considered? (e.g. remote video)
12. Are there unintended consequences of the model that need to be taken into account?
13. Are there interdependencies in the model that have not been to be taken into account?
14. Have the risks and consequences of sustaining the model of care been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?

### **Scope of the review:**

In scope:

- Maternity services delivered by UHMBT, RCOG Option 1.

Out of scope but with clear interdependencies which need to be considered:

- Paediatrics services, anaesthetics and surgery.
- It is recognised that the establishment of the STP introduces a new dynamic into the planning of maternity services across the footprint of Lancashire and South Cumbria. This review by the Clinical Senate does not pre-empt discussions that may take place regarding the future of maternity services across the STP footprint.

Out of scope:

- Service options other than RCOG Option 1

### **Outline methodology:**

Methodology will consist of:

- A desktop review of the supporting documentation and update statement, including highlighting any gap in evidence that has been considered<sup>4</sup>
- Clinical expertise and opinion
- Interview with clinical lead and other local colleagues as required by the panel
- Locality visit

**Timeline:** [start/finish date]

May – November 2017

### **Reporting arrangements**

The clinical review team will report to Prof Donal O'Donoghue, Lead Senate Chair, on behalf of the North Region Clinical Senate, who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the media handling of the report and subsequent publication of findings will be agreed within 3 months of delivery.

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<sup>4</sup> This may need to be facilitated by a workshop.

### 3. KEY PROCESS AND MILESTONES

Process	Milestone
Discussion with Clinical Senate Chair and Medical Director	6/3/17
Discussion with Clinical Senate Chair, Commissioner and Review Team Lead	29/6/17
Information for review submitted by Commissioner and distributed to review team, including update statement regarding UHMBT response	19/6/17
Review Team teleconference(s)	5/7/17
Requests for clarification and/or further information from Commissioners	10/7/17
Further information provided by Commissioners	21/7/17
Desktop exercise with review panel and commissioners	TBA
Panel visit to Morecambe Bay area (interviews and overview of area)	10&11/10/17
Panel submit final edits and report writing for submission	13/10/17
Draft report sent to commissioners for comment	3/11/17
Feedback on accuracy of report content from commissioners	10/11/17
Final report ratified by GMLSC Senate Council	17/11/17
Final report issued by Clinical Senate to CCG	20/11/17

### 4. REPORT HANDLING

A draft clinical senate report will be made to the sponsoring organisation on 3/11/17 for fact checking with comments/ corrections from Commissioners received by 10/11/17. The final report will be submitted by the Clinical Senate to the sponsoring organisation by 20/11/17. The report will be ratified remotely by the Clinical Senate Council in its meeting on 17/11/17.

### 5. COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made. The Clinical Senate is aware of the sensitivities related to service change and reconfiguration and so an agreement will be reached in discussion with the sponsoring organisation in relation to the timing and process of publication. All media enquiries will be handled by the sponsoring organisation via the named communication lead from the sponsoring commissioner, Julia Westaway.

### 6. RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

## **7. ACCOUNTABILITY AND GOVERNANCE**

The clinical review team is part of the GMLSC Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

## **8. FUNCTIONS, RESPONSIBILITIES & ROLES**

The sponsoring organisation will:

- I. Provide the clinical review panel relevant information, this may include: with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
- II. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- III. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
- IV. Submit the final report to NHS England for inclusion in its formal service change assurance process.
- V. Clinical senate council and the sponsoring organisation will
- VI. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate council will:

- I. Appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- II. Advise on and endorse the terms of reference, timetable and methodology for the review.
- III. Consider the review recommendations and report (and may wish to make further recommendations).
- IV. Provide suitable support to the team and submit the final report to the sponsoring organisation

The Clinical review team will:

- I. Undertake its review in line the methodology agreed in the terms of reference.
- II. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

- III. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- IV. Keep accurate notes of meetings.
- V. Clinical review team members will undertake to Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).
- VI. Contribute fully to the process and review report
- VII. Ensure that the report accurately represents the consensus of opinion of the clinical review team
- VIII. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the review panel.

## Appendix 2 - Programme for visit on 10th and 11th October 2017

### DAY 1:

Date: 10th October 2017 / Time: 10:45am–19:30pm

Time	Item	Details	
Review Panel Pick Up – Lancashire House Hotel, Green Lane, Ellell, Lancaster, LA1 4GJ			
10:45am - 12:00pm	Travel to Furness General Hospital	Dalton Lane, Barrow-in-Furness, Cumbria, LA14 4LF	Minibus / Car Share
12:00pm - 12:30pm	Arrival at FGH Education Centre	Meet & Greet - Lunch	Julia Westaway / Shahedal Bari / Exec Team
12:30pm - 13:30pm	Walking tour of site		
13:30pm - 14:00pm	Discussion with Trainees		
14:00pm – 15:30pm	Travel to Royal Lancaster	Ashton Road, Lancaster, LA1 4RP	Minibus / Car Share
15:30pm – 16:00pm	Arrival at RLH	Meet & Greet – Tea/Coffee Break	Julia Westaway / Shahedal Bari / Exec Team
16:00pm – 16:45pm	Walking tour of site		
16:45pm – 17:15pm	Discussion with Trainees		
17:15pm – 19:00pm	Return Travel Review Panel Discussion & Feedback	Lancaster House Hotel - Meeting Room	

**DAY 2:****Date: 11th October 2017 / Time: 08:45am –13:30pm****Meeting & Discussion with both Furness General Hospital & Royal Lancaster Hospital Staff**

Time	Item	Details
<b>08:45am – 09:00am</b>	Arrival	Paediatric Seminar Room
<b>09:00am – 10:00am</b>	Discussion & QA Session	Clinical Teams
<b>10:00am – 10:30am</b>	Discussion & QA Session	Midwifery Staff
<b>10:30am – 11:00am</b>	Refreshment Break and Review Panel Discussion	
<b>11:00am – 12:00pm</b>	Discussion & QA Session	Executive Teams
<b>12:00pm – 13:30pm</b>	Conclusions, Feedback and Next Steps	Review Panel & CCG
Review Panel Pick Up – Return Travel to Lancashire House Hotel, Green Lane, Ellell, Lancaster, LA1 4GJ		