Royal College of Obstetricians & Gynaecologists

REPORT

Review of Obstetrics and Gynaecology Services at East Kent Hospitals University NHS Foundation Trust

On 24, 25 and 26 November 2015

Undertaken by:
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1. INTRODUCTION

This review has been commissioned by Dr Paul Stevens, Consultant Nephrologist and Medical Director of East Kent Hospitals University NHS Foundation Trust, following concerns about the working culture within women's health services including relationships and communication between midwives and obstetricians. Issues of concern are an inconsistent compliance with national standards amongst obstetricians, poor governance in relation to serious incidents, staffing, education and supervision of obstetric middle grades and trainees and consultant accessibility and responsiveness. Concerns relating to consultant presence on the delivery suite as per RCOG recommendations have also been raised.

2. NAMES OF REVIEW TEAM MEMBERS

Lead Assessor:
Dr Claire Candelier,
Consultant Obstetrician and Gynaecologist
Stepping Hill Hospital, Stockport

Co-Assessors:
Dr Teresa Kelly,
Consultant Obstetrician and Gynaecologist
Central Manchester Hospital Trust

Joy Kirby,
LSA Midwifery Officer
Substantive role in the Nursing Directorate NHS England – Midlands and East

Alison Whitham,
Head of Midwifery
Sherwood Forest Hospitals

Dr David Milligan,
Consultant Neonatal Paediatrician (retired)

3. TERMS OF REFERENCE

1. To review the Maternity Services' Governance Board terms of reference, membership and reporting arrangements.

2. To review how serious incidents (SI) are identified, reported and investigated within the Maternity Services; how recommendations from investigations are acted upon by the Maternity Services and how processes ensure sharing of learning amongst clinical staff, Board and senior management.

3. To review how the SI process links with the supervision process both internally and at LSA level and how supervision is managed for both student and registered midwives.

4. To advise on seven specific SI cases from Q3 and Q4 of 2014/15 including review of investigation process, involvement of patients, carers and family and make recommendations for change.

5. To review the current provision of care within the Maternity Services in relation to national standards (NICE, RCOG, RCPCH, BAPM and RCM).

6. To review the current obstetric consultant/middle grade workforce and staffing rotas in relation to safely delivering the current level of clinical activity and clinical governance responsibilities.

7. To review the education and supervision of obstetric middle grades and trainees including consultant accessibility and presence on the delivery suite as per RCOG recommendations in the context of providing a safe and efficient service.

8. To review the working culture within the Maternity Services including relationships and communication between midwives, trainees, obstetricians and neonatologists.

9. To identify any concerns that may prevent staff raising patient safety concerns within the Trust.

10. To make recommendations based on the findings and highlight significant differences that may exist between the two maternity sites in relation to outcomes and culture, guidelines, governance arrangements and serious incident reporting.

4. CONTEXT

East Kent Hospitals University NHS Foundation Trust (EKHUFT) is a large trust offering care to a population of approximately 759,000 people across four main hospital sites and a number of community hospitals. Antenatal, intrapartum and postnatal care is provided across 800 square miles in two consultant units, two co-located midwifery-led units and the community. There are approximately 7,000 births a year.

The William Harvey (WH) Hospital in Ashford and the Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate both offer obstetric-led and co-located midwifery-led maternity units. There are 12 community based midwifery teams serving both hospitals. Two satellite units, the Buckland Hospital in Dover and the Kent and Canterbury Hospital in Canterbury offer a maternity day-care service, seven days a week. Obstetric scans are offered on all sites as well as in two satellite community hospitals in Folkestone and Deal.

A Fetal Medicine service is provided on both acute sites offering invasive procedures. Neonatal care is provided on both acute sites, level 3 NICU care at the WH Hospital and level 2 at the QEQM Hospital.

5. DESCRIPTION OF REVIEW PROCESS AND SITES VISITED

The Medical Director of East Kent Hospitals University NHS Foundation Trust contacted the RCOG following which five assessors were selected with relevant experience related to the terms of reference.

The assessors requested specific information and data from the Trust which was received by the assessors prior to the review. The medical records of the available index cases together with records of cases of severe pre-eclampsia, maternal collapse, caesarean section for major placenta praevia, massive obstetric haemorrhage, return to theatre for laparotomy that occurred on both sites during the Q3 and Q4 of 2014/15 were reviewed by two of the assessors.

The interviews took place on the 24-26 November at Kent and Canterbury Hospital, QEQM Hospital in Margate and at the WH Hospital in Ashford. The list of interviewees is detailed below:

Tuesday 24th November 2015
Trust Medical Director: Paul Stevens
Divisional Director: Trish Hubbard
Clinical Lead and Site Lead WHH: Kate Neales
Head of Midwifery: Helen Bland
Directorate's Governance Lead: John Seaton
NICU Lead for QEQM: El-Hussein Rfidah
Divisional Medical Director: Ian John

Wednesday 25th November 2015
NICU Lead for WHH: Vimal Vasu
Supervisor of Midwives: Rebecca Tebbett-Ford
SAS Doctor QEQM: Nimmi Othayoth
Postgraduate Medical Education Lead QEQM, O&G Consultant: Zoe Woodward
O&G Consultant QEQM: Ike Okorocha
GPST1 O&G: Daniel Wheeler
Student Midwife QEQM: Amy McCabe
Labour Ward Co-ordinator QEQM: Moyra Smith
Labour Ward Midwife QEQM band 7: Peyma Hajilou
ST3 O&G QEQM: Adil Todiwala
Matron QEQM: Kerri Ellersten-Feeney
Community Midwife Matron: Hannah Horne
O&G Consultant QEQM: Hasiba Hamoud
O&G Consultant QEQM: Prakash Belgaumkar
O&G Consultant QEQM: John Shervington
Midwife: Sarah Spooner

Thursday 26th November 2015
Supervisor of Midwives: Laura Ovenden
Lead Consultant for Obstetric Anaesthesia QEQM: Jonathan Hudsmith
Labour Ward Co-ordinator WHH: Jeanette Salisbury
Midwifery Sister Band 7: Angeline Fellowes
Director of Medical Education: Prathibha Badipalyan
Student Midwife WHH: Jessica Ryn
Clinical Governance Midwife: Joanna Olagboyega
Clinical Governance Matron: Michelle Burrogh
SAS Doctor WHH: Emmanuel Woluchem
Postgraduate Medical Education Lead WHH, Lead Labour Ward Consultant: Choy Lee
ST5 O&G WHH: Christina Aung
O&G Consultant WHH: Abhijeet Shah
O&G Consultant WHH: Niji Agboola
O&G Consultant WHH: Keyuri Shroti
O&G Consultant WHH: Brian Wise
O&G Consultant WHH: Godswill Etokowo
Lead Consultant O&G QEQM: Graham Ross
Guideline Co-ordinator: Anne Heseltine

GP Trainee WHH: Arjun Sohanpal
Associate Specialist WHH: Wael Helmy
Trust Clinical Risk and Governance Lead: Michelle Webb
HEKSS Head of School: Sarah Flint (by phone)

Anastasia Gourumenou, O&G Consultant QEQM, was unable to be interviewed due to on-call commitments. John Rampton, Labour Ward Anaesthetic Lead Consultant WHH, was unable to be interviewed but sent by email his responses to interview questions.

Following interviews and gathering of documents, the evidence was reviewed and a report prepared.

6. DOCUMENTATION SOUGHT FROM THE TRUST

The documentation detailed below was received:

- Management structure of the service and overview
- Working arrangements for the maternity service
- Job plans, job descriptions (medical and midwifery)
- Labour ward staffing rota for junior and consultant medical (obstetric, anaesthetic and neonatal) staff
- RCOG Speciality department visit completed questionnaires for both sites (appendix 1 & 2)
- LSA Annual Audit Report
- East Kent SoM Audit Action Plan, 2014-15
- Workload statistics
- Maternity dashboards
- MBRRACE-UK perinatal mortality report: 2013 births
- RCOG Clinical Indicators Project – Maternity National Results 2015
- Women's Experience of Maternity Care, 2015 Quality Health report
- Clinical Audit Strategy 2013-15
- Clinical governance and risk management strategy, October 2014
- Risk management strategy, November 2014
- Incident management policy, June 2015
- Incident reporting pathway, RCA flash course
- Post adverse event staff support checklist
- Policy for management of complaints, concerns, comments and compliments
- Guidelines for the management of complaints, January 2015
- Policy for implementation of NICE guidance and quality standards
- Antenatal/Postnatal communication and safeguarding risk assessment
- Clinical governance: forums, perinatal and maternity morbidity meetings local and trust wide with examples of cases presented and attendance lists
- Investigation reports with recommendations and action plans for the seven SI cases from Q3 and Q4 of 2014/15 referred to under paragraph 4 of the ToR
- Clinical care protocols/ guidelines relating to the above SI cases
- Current obstetric protocols/ guidelines
- Policy for Consultant Obstetricians, referral to and attendance on Labour Ward when on call, March 2015

- Clinical Handover of Care Policy
- GMC training survey reports for 2014 and 2015
- Raising Concerns (Whistleblowing) Policy and Procedure

7. SYNOPSIS OF INDEX CASES AND CONCERNS

Relating to Terms of Reference:

To advise on seven specific cases including review of investigation process, involvement of patient, carers, family and make recommendations for change

7.1 Case 1

Brief Background:

This 40 year old woman in her second pregnancy had planned a vaginal birth after caesarean section (VBAC) at home against medical advice. Her first labour had ended in an emergency caesarean section delivery for suspected fetal compromise. The woman employed a doula to support her during the birth. She discussed plans for birth with her community midwife, a consultant midwife, two obstetric consultants and a supervisor of midwives all of whom advised against a home birth because of the previous caesarean section but also because of her short stature. She was advised to give birth in hospital and to have continuous fetal monitoring in labour as per local and national guidelines.

The woman went into spontaneous labour at term and went to a friend's house in Margate to be nearer the QEQM hospital should problems arise. Community midwives were called to attend the home at 09.30hr. There was slow progress in labour and a vaginal examination planned for 15.30hr was deferred by the woman until 16.00hr. Following this examination the midwife advised transfer to hospital. Discussions about method of transfer took place. The woman agreed to transfer by ambulance at 16.40hr.

The woman declined continuous monitoring in hospital and the midwife listened to the fetal heart intermittently in line with the wishes of the woman. At 18.15hr the fetal heart rate dropped several times and was slow to pick up. It was advised that continuous monitoring be commenced and the woman agreed to hand held electronic fetal monitoring at 18.20hr. The woman discussed this with the doctor and the doula and initially requested that the monitor be held on by hand as she did not wish to have straps on. After a further deceleration, the doctor again advised continuous monitoring. At 18.37hr continuous monitoring of the fetal heart was started and a pathological trace seen. A category 1 emergency caesarean section was performed under general anaesthetic. The baby was born at 19:07hr severely asphyxiated and resuscitation measures commenced. The baby was stabilised and transferred to St Georges Hospital, London, where treatment was withdrawn and the baby subsequently died.

Rigour of RCA Investigation:

Evidence of appropriate multidisciplinary involvement

The investigation team were the assistant head of midwifery (HoM) and the clinical governance lead. The report author was the clinical governance midwife and the assistant HoM. There is no evidence that the incident was referred to the SoM team. The parents were informed of the investigation and asked that three specific questions be answered.

Adequate time frame

The Executive sign off was three and a half months after the incident had occurred with the date for submission to the CCG as one month earlier. The investigation therefore took 78 working days to complete.

Identification of all issues

Without access to the medical records it is difficult to tell whether all issues have been identified. However, the care, treatment and service delivery problems identified that the woman was unhappy and upset by the advice given by the obstetric consultant about recommending hospital birth. Later on, a second opinion was sought from another consultant who also advised against a home VBAC.

The consultant midwife declined the woman's request to birth in the midwifery led unit as she did not fulfill the admission criteria. Plans had been made by the woman to labour in a house close to the hospital in case of need to transfer in. The midwife caring for the woman was not previously known to her and there was also a student midwife providing care. As a complex homebirth it would have been better for this woman to have been attended by her named midwife.

Parental decision to labour at home with intermittent monitoring of the fetal heart was taken against medical advice given by two different obstetric consultants and one consultant midwife. The fetal lie had been correctly identified as being in an occipito-posterior position, or 'back to back'. This can lead to a slower more difficult labour and also spontaneous urges to push when not fully dilated. The woman questioned the need for a vaginal examination at 15:30hr and delayed the decision to 16:00hr which further impacted on the detection of slow progress and eventual transfer to hospital.

The woman employed a doula and there was lack of clarity around the role of the doula. It was felt by the attending midwives that the doula created a barrier to communication between the woman and the midwives.

The root cause was identified as delayed detection of fetal distress due to limitations of intermittent auscultation in a high risk VBAC pregnancy as this method of auscultation will not always detect fetal compromise. This was clearly explained to the woman in the antenatal period. Continuous CTG monitoring may have altered the outcome due to earlier detection of fetal distress and subsequent intervention.

Action plans with specific directives, time scales, and evidence of achievement

There is evidence of an action plan with specific directives, time scales and evidence of achievement. The action plan is fully completed with no outstanding actions. It appears to have been completed in a timely manner.

Incident discussed at appropriate meetings

The incident was presented at the Perinatal Mortality and Morbidity meeting and was presented to the Board at a Quality meeting in January 2015.

Evidence lessons have been learnt by midwives and medical staff

The action plan has a number of actions related to detailed planning regarding care provision for women with high risk pregnancies and labours wanting to birth at home, including adequate assessment of the home. The action plan highlighted that there has been no midwifery supervision involvement in the

woman's care but failed to comment on the lack of supervision involvement in the investigation process. The action plan had no outstanding actions.

Comments

The investigation did not acknowledge or appear to accept any responsibility on behalf of the Trust. There appeared to be an implication that what happened was entirely the woman's own fault. The assessors felt there were a number of barriers put in the woman's way which did not aid good communication between the Trust and the woman. There is no recognition of this in the report.

The issue of a lack of a VBAC specialist clinic was not considered in the report. The woman first saw a registrar and then a consultant in a routine antenatal clinic. She has previously experienced, in her opinion, poor care in her first labour, and wanted to have a home birth to minimise unnecessary interventions and to optimise her chance of a normal birth. The woman was dissatisfied by the attitude of the consultant and requested transfer to another. Again this aspect of care provision was not thought to be an issue by the investigation team and was not investigated.

There was no recognition that the woman would have birthed in the midwifery-led unit if she had been allowed to. It would not have been unreasonable for the feasibility of this option to have been explored further with supervision involvement. In the assessors opinion had the woman laboured in the co-located midwifery-led unit rather than at home, the outcome may well have been different.

7.2 Case 2

Brief Background:

This woman with two previous vaginal births attended the midwifery-led unit at William Harvey Hospital following spontaneous onset of labour at term+8 days. After a slow latent phase, she established in labour and laboured in the pool. Maternal observations were normal and intermittent fetal heart rate auscultation was reassuring. The plan was for her to transfer to the labour ward for intravenous antibiotics once she was 24 hour post rupture of membranes but this was not possible as the labour ward was closed due to the high level of activity.

She continued labouring in the pool where she delivered a male infant in poor condition, Apgar of 1 at 1 minute of birth. Cord gases were arterial pH7.28, venous pH6.91. Following resuscitation, the baby was transferred to the neonatal intensive care unit and was ventilated for four days. He received head cooling for three days. He was diagnosed with Hypoxic Ischaemic Encephalopathy Grade 1. He was discharged home on day eight and will be followed up in the outpatient neurodevelopment clinic.

Rigour of RCA investigation:

Evidence of appropriate multidisciplinary involvement

The investigation team were a consultant midwife and a consultant neonatologist. The report author was the clinical governance midwife. There is no documentation regarding the woman and partner being offered a meeting to share the investigation findings and a copy of the report.

Adequate time frame

The Executive sign off was two and a half months after the incident occurred (wrong year noted on RCA Investigation Report) with the date for submission to the CCG as 20 days later.

Identification of all issues

The medical records were available to the assessors during their visit to the Trust. Midwifery documentation was good regarding plan of care in the latent phase of labour, vaginal assessments, and the need for intravenous antibiotics once 24 hr from spontaneous rupture of membranes. Fetal heart rate auscultation appears appropriate from reading the records.

The RCA investigation report concurs with the findings from the records review. The care, treatment and service delivery problems identified that the woman's mental health issues identified at booking were not followed up as per unit policy, no advice was documented by a midwife following a phone call from the woman to the MLU, and the inability to transfer the woman to the labour ward due to clinical activity was not escalated by the midwife to the manager or supervisor on call.

Action Plans with specific directives, time scales, evidence of achievement

There is evidence of an action plan with specific directives, time scales and evidence of achievement. Not all action plans are completed but those outstanding are on-going with evidence of work in progress.

Incident discussed at appropriate meetings

The incident was presented at a Perinatal Mortality and Morbidity meeting and at a Supervisors of Midwives meeting. The incident was presented at the Divisional Governance Board and the Quality Assurance Board.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in the "Risky Business" newsletter. They were also circulated in the "Supervision News" to all midwives.

Comments

The assessors felt this investigation was comprehensive. Each recommendation had robust action plans made and either achieved or on-going. The failure of the midwife to escalate a situation in a timely manner was particularly well addressed by the investigating team with action plans for midwife reflection and learning in her portfolio, discussion with the RCA investigator in her capacity as Supervisor of Midwives (SoM) and in due course sharing of the reflective piece at her annual appraisal with her own SoM.

The baby suffered from Hypoxic Ischaemic Encephalopathy (HIE) Grade 1 with cord gases indicating an acute intrapartum hypoxic event. In view of this, the assessors felt the investigators should have ascertained the appropriateness of fetal heart rate monitoring during labour and delivery.

7.3 Case 3

Brief Background:

This primigravida was admitted to the labour ward at the QEQM Hospital for augmentation of labour following spontaneous rupture of membranes at 39 weeks gestation. As she was in labour, syntocinon® was not commenced. She reached full cervical dilatation at 17.30hr. The CTG trace was classified as suspicious since 17.00hr. Active pushing started at 18.40hr and a syntocinon® infusion was started at 18.55hr after discussion with the band 7 midwife to increase contraction frequency. At 20.30hr the syntocinon® infusion was stopped after a prolonged fetal bradycardia. After review by the registrar, the woman was taken to theatre for an instrumental trial delivery. At 21.34hr, a baby girl was delivered by

ventouse with the cord wrapped tightly round her neck. She was transferred to the neonatal unit due to sternal recession and grunting. On examination, she was found to have a pneumothorax. She was transferred to Brighton Hospital for further intensive support, including head cooling. Five days later, she was transferred back to the QEQM Hospital with eventual discharge home. No follow-up was required.

This incident was not automatically reported as a clinical incident when the baby was transferred from labour ward but was detected following admission to the neonatal unit.

Rigour of RCA investigation:

Evidence of appropriate multidisciplinary involvement

The reviewers for this investigation were a locum consultant obstetrician, a consultant midwife and a band 7 midwife. The report authors were the consultant midwife and the band 7 midwife. The woman was informed of the investigation process.

Adequate time frame

The investigation took over four months to reach executive sign off. A time extension was granted by the CCG due to a delay in obtaining the patient's records.

Identification of all issues

Without sight of the relevant notes, the assessors cannot confirm that all issues were identified. The care, treatment and service delivery problems identified that syntocinon® was commenced by a midwife in the second stage of labour in the presence of a suspicious CTG trace and without referring the woman for review by an obstetrician.

Action plans with specific directives, time scales, and evidence of achievement

There is evidence of an action plan with specific objectives, time scales and evidence of achievements. The two recommendations concerned use of syntocinon® in the second stage of labour and obstetric referral. Recommendations were signed off as achieved although the midwifery practice issue was outstanding as the midwife in question was on retirement leave but planning to return to work part-time at the Trust. Guideline wording was also changed to stop the existing practice of midwives using syntocion® without a doctor's prescription.

Incident discussed at appropriate meetings

The case was discussed at the perinatal morbidity and mortality meeting. The case was also for review at the Specialist Services Governance Group, no date confirmed.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in "Risky Business".

Comments

This investigation highlighted the practice of midwives using syntocinon® without it being prescribed by a doctor. It appears that guidelines for prescribing were not followed. The incident action plans should rectify this unacceptable and potentially dangerous practice.

At 16.00hr, the CTG trace was documented as suspicious. At 17.00hr, a fresh pair of eyes again noted variable shallow decelerations and reduced variability. At 17.30hr the SHO reviewed the trace and suggested review in 20mins. No further obstetric review appears to have occurred until registrar attendance at 20.44hr prompted by a prolonged bradycardia. The assessors feel the interpretation of the CTG trace should have formed part of the investigation process. A trace with reduced variability and/or variable decelerations for over 90 minutes is no longer suspicious but pathological. Normal practice is to advise a fetal blood sample be taken. Without seeing the actual CTG trace, it is difficult to comment further.

7.4 Case 4

Brief Background:

This 36 year old primigravida booked for consultant-led care, having suffered a stroke in 2013. At term+11 days she was admitted in labour at WH Hospital. A CTG trace commenced at 09.50hr was categorised as suspicious. At 10.10hr, artificial rupture of membranes was performed with thick meconium present. At 10.10hr, the decision was made for a category 1 caesarean section as the trace was now pathological. At 11.03hr the woman was transferred to theatre with delivery of a female infant in poor condition at 11.26hr. The paediatric SHO was present at delivery and the registrar was crash bleeped in view of the baby's poor condition. Venous cord gases were pH 6.99 with a base excess of -16.5. After initial resuscitation, the baby was handed to parents and for neonatal review in two hours. At 14.30hr, the baby was admitted to the neonatal intensive care unit (NICU) with hypothermia, hypotonia, nasal flaring and chest recession. She was ventilated until day four of life, requiring inotropic support until day three. She fitted at 12 hours of age and was on anticonvulsants until day four. She remained on the NICU for 16 days. Outpatient follow-up was arranged in the neurodevelopment clinic. Diagnosis was Grade 2 Hypoxic Ischaemic Encephalopathy (HIE).

Rigour of RCA Investigation:

Evidence of appropriate multidisciplinary involvement

The reviewers for this investigation were the antenatal and newborn co-ordinator, a consultant obstetrician, a consultant neonatologist and the neonatal matron. The report authors were the antenatal and newborn co-ordinator, neonatal matron and clinical governance matron. The parents were offered a meeting to share the investigation findings and a copy of the report.

Adequate time frame

The investigation took just under four months to reach executive sign off.

Identification of all issues

Without sight of the relevant notes, the assessors cannot confirm that all issues were identified. The care, treatment and service delivery problems identified that the fundal height was not plotted consistently throughout the antenatal period on the GROW chart, scans were not plotted on the customised growth chart, there was a delay in performing a category 1 caesarean section, cord pH results were unavailable and the birth weight was incorrectly recorded. The investigators were of the opinion the delay in performing the delivery was unlikely to have affected overall outcome and graded the incident as low harm. They also felt it was an error of judgement of the neonatal registrar not to have requested/ followed-up results of cord gases. Had the baby been admitted to NICU sooner, ventilation problems may have been avoided.

Action Plans with specific directives, time scales, evidence of achievement

There is evidence of an action plan with specific objectives, time scales and evidence of achievements. The recommendation to amend the documentation, to state that the baby must be weighed within six hours of admission to the neonatal unit has not been signed off as achieved.

Incident discussed at appropriate meetings

The case was discussed at the perinatal morbidity and mortality meeting. The case was also for review by the Women's Health Clinical Governance Forum and the Specialist Services Quality and Governance Board. It was also planned for presentation to Quality Assurance Board.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in "Risky Business" but there is no evidence of wider learning. During interviews the assessors were repeatedly told of the lack of wider learning from RCA investigations, lack of individual feedback when involved in a clinical incident, lack of awareness on changes in practice/ guidelines. The impression given was of a tick box exercise, once put in risky business and presented at perinatal meetings nothing else was needed.

Comments

The investigation did not review the woman's antenatal care beyond the failure to plot measurements and estimate fetal weights. This woman suffered a stroke prior to pregnancy and her antenatal care providers should have included a consultant neurologist as well as obstetrician. It would be usual practice to offer such women low-dose aspirin antenatally and to request routine growth scans.

The assessors are concerned the investigators seem to almost dismiss the significance of the delay in delivery with eventual outcome, Grade 2 HIE, and therefore grade this as a low harm incident. Had the baby been delivered 30 mins earlier, it is the opinion of the assessors that, more than likely, the baby would have been born in better condition.

Decision for delivery by category 1 caesarean section was made at 10.30hr and the woman was transferred to theatre at 11.03hr, over 30 mins later. No investigation into this delay was undertaken as part of the review such as review of guidelines (if any exist) for preparation and transfer of women requiring emergency delivery and staff actions. The registrar failed in his/her duty of care to ensure the baby was delivered within the 30 mins recommended interval. Recommendations should have been made for him/her to see his/her educational supervisor and to reflect on this incident.

Although the investigators felt an error of judgement was made by the neonatal registrar, no actions were taken to address this and prevent recurrence of error. Again a piece of reflective practice and discussion with the educational supervisor should have been the minimum recommendations made for that registrar.

7.5 Case 5

Brief Background:

This 40 year old woman suffered from a primary postpartum haemorrhage, retained placenta and first degree vaginal tear following a vaginal birth complicated by a shoulder dystocia. At 06.55hr, the obstetric registrar requested that the woman was transferred to theatre for a manual removal of placenta. At the time of the anaesthetic review at 07.05hr, estimated blood loss (EBL) was 1000ml. EBL at time of arrival in

theatre was 1600ml. At 07.38hr, the woman's readings were heart rate 130, oxygen saturation 98% and blood pressure 97/59. The intravenous Hartmann's infusion was increased. Shortly after insertion of the spinal anaesthesia, the woman suffered a circulatory collapse secondary to hypovolaemia. Cardiopulmonary resuscitation was commenced and, once circulation had been restored, the operation was performed under general anaesthesia. The woman was debriefed on two occasions by the anaesthetic team before her discharge home from William Harvey Hospital.

Rigour of RCA Investigation:

Evidence of appropriate multidisciplinary involvement

The reviewers for this investigation were a consultant anaesthetist, the clinical governance midwife and the surgical governance matron. The report author was the consultant anaesthetist. The woman was written to regarding events and asked to make contact if she had any queries. Investigation findings and a copy of the investigation report were not offered to the woman.

Adequate time frame

The investigation took five months to reach executive sign off.

Identification of all issues

Without sight of the relevant notes, the assessors cannot confirm that all issues were identified. However, from the history available, it appears that the care, treatment and service delivery problems were identified. The root cause was a failure to fluid resuscitate a woman with a significant blood loss postpartum prior to insertion of a spinal as per the "Postpartum Haemorrhage" guideline.

Action Plans with specific directives, time scales, evidence of achievement

There is evidence of an action plan with specific objectives, time scales and evidence of achievements. However, only one of the five recommendations has been signed off as achieved.

Incident discussed at appropriate meetings

The case was for review at the Surgical Clinical Governance board, no date listed. The incident was planned for presentation to Quality Assurance Board with an updated action plan.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in 'Risky Business' and circulated electronically to anaesthetic staff and the theatre matron.

Comments

The investigation report is comprehensive. However four of the five action plans had not been signed off at time of submission to the CCG. The investigators correctly identified practice issues with the registrar anaesthetist who should have obtained a baseline blood pressure reading before commencing insertion of spinal anaesthesia in a woman with a marked tachycardia and with an EBL of 1600ml. Failure to fluid resuscitate before the insertion of spinal anaesthesia precipitated this woman's cardiovascular collapse. The assessors are concerned this individual's competence has not been specifically addressed in the action plans. No steps have been put in place to ensure this individual has learnt from his/her error. Part of the action plan should have been a reflective practice piece by the registrar, a meeting with his/her educational

supervisor and possibly a period of clinical supervision to minimise the risk of this serious event happening again with this trainee. To ensure patient safety, an assessment of the anaesthetic registrar's competence should have occurred before his/her next clinical shift.

7.6 Case 6

Brief Background:

This primigravida was admitted to QEQM maternity ward following review by the SHO at 23^{+1} weeks of gestation. The woman was on long-term antibiotics because of recurrent urinary tract infections in pregnancy. She suffered from medullary sponge kidneys and was under the care of nephrologists. On admission she was unwell with a raised temperature and tachycardia. Plan of care was fluids and intravenous antibiotics following a discussion with the microbiologist. This plan of care was not instigated overnight.

After review by a SHO the following morning, she commenced intravenous fluids. The woman's condition worsened during the day and, following consultant review at 15.15hr, she was commenced on intravenous antibiotic therapy after discussion with microbiologists. The woman's condition worsened and she required admission to the Intensive Care Unit the following day.

Rigour of RCA Investigation:

Evidence of appropriate multidisciplinary involvement

The reviewers for this investigation were the midwifery matron at the QEQM Hospital and a consultant obstetrician and gynaecologist. The woman was informed that this investigation was taking place. The report does not mention either a meeting to share the investigation findings or offer of a copy of the report to the woman.

Adequate time frame

The investigation took over four months to reach executive sign off.

Identification of all issues

Without sight of the relevant notes, the assessors cannot confirm that all issues were identified. The care, treatment and service delivery problems identified that the delay in commencing appropriate treatment and in escalation to microbiology contributed to the woman's deteriorating health, stent insertion and admission to the Intensive Care Unit. The woman's observations were not monitored overnight.

Unknown to the matron, the attending midwife's practice was being managed through statutory supervision.

The locum registrar did not review the patient overnight despite the woman's details being on the handover sheet. There was no review by either a registrar or a consultant the following morning. The woman was reviewed at 15.00hr when the midwife requested consultant review due to her worsening condition.

Action Plans with specific directives, time scales, evidence of achievement

There is evidence of an action plan with specific objectives, time scales and evidence of achievements. All recommendations have been signed off as achieved. The action plans focus on the performance

management of the midwife caring for the woman overnight. The NPSA Incident Decision Tree (IDT) tool was used to help address this individual's professional practice. The registrar was required to produce a reflective piece and discuss at his/her next appraisal.

Incident discussed at appropriate meetings

The case was discussed at the perinatal morbidity and mortality meeting. The case was presented to Quality Assurance Board and was planned to be reviewed at the Division Governance Review meeting.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in "Risky Business" with handover of care issues highlighted.

Comments

The investigation recommended that "all high risk antenatal women should be reviewed by a registrar". The woman was admitted following SHO review at 19.45hr, was reviewed at 08.30hr the following day by a SHO. Consultant review occurred at 15.00hr (20 hours after her emergency admission) following request by a midwife due to her deteriorating condition. The reason given for lack of a registrar review at 08.30hr was that he/she may have been busy covering caesarean sections. The assessors are of the opinion the consultant on-call should have reviewed this emergency admission as she was an emergency admission and was high-risk. Failure to do so should have been investigated in the root cause analysis. A required standard of care for NHS services is that "all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at least within 14 hours from time of arrival at hospital"[1]. This clearly did not happen here and no action plans have been made by the investigating team to prevent such an incident occurring again.

7.7 Case 7

Brief Background:

A primigravida booked for low risk care. She had an uneventful antenatal period. At 40 weeks+2 days gestation she was brought to labour ward at William Harvey Hospital by ambulance in labour. During the ambulance transfer she was noted to have two episodes of raised blood pressure but was asymptomatic of pre-eclampsia. On arrival her blood pressure was 158/118 and she was reviewed by an obstetrician. She was treated as per the pre-eclampsia protocol and an intravenous infusion of hydralazine commenced to control her blood pressure. A vaginal examination was performed and cervical dilatation was 1cm. The plan was to augment labour once the blood results were available and her blood pressure had stabilised. Continuous cardiotocogram (CTG) was used and the trace was interpreted as suspicious. At the next vaginal examination, her cervix was 3cm dilated and artificial rupture of membranes was performed. The presence of thick meconium was noted. A decision was made to use STAN (ST-Analyser) to monitor the labour, but when the fetal scalp electrode was attached, no fetal heart could be heard. A bedside ultrasound scan was performed and the fetal heart was seen to be 20 beats per minute. A decision for a grade 1 caesarean section delivery was made and the baby delivered within 9 minutes with a large retroplacental clot evident. The baby was born in very poor condition and taken to the neonatal intensive care unit where he died within an hour of delivery.

[1] NHS Services, seven days a week forum 2013.

Rigour of RCA Investigation:

Evidence of appropriate multidisciplinary involvement

The reviewers for this investigation were the community matron, MLU co-ordinator and consultant obstetrician and gynaecologist. It may have been beneficial for a midwife from another area to have undertaken the investigation given that some issues occurred in the community and MLU. The report author was the clinical governance matron. Given that this was a neonatal death there was no involvement of a neonatologist. There is evidence that the parents were involved and a copy of the investigation findings were to be sent to the family on completion. The case was referred to the SoM team as per the LSAMO Serious Incident guidance.

Adequate time frame

The investigation took 70 working days with the final submission to the CCG a further month later. However, there is evidence of a request for an extension to the time from the CCG due to differing clinical opinions regarding interpretation of the CTG.

Identification of all issues

Without sight of the relevant notes, the assessors cannot confirm that all issues were identified. However, the care, treatment and service delivery problems identified that the woman booked late and should have been referred to a consultant pathway and that there was a delay in escalation and review by the obstetric team on admission.

Once the woman arrived on the labour ward there was a delay of 55 minutes before commencing a CTG. The woman was high risk on arrival due to her raised blood pressure and had no felt fetal movements since 23.00hr the day before. Once the CTG was commenced at 06.44hr, the initial CTG trace pattern did not indicate immediate intervention. The priority at this time was to stabilise her blood pressure.

At consultant review at 09.40hr, the CTG trace was classed as suspicious and was still suspicious at 10.30hr. At 11.30hr the registrar classified the trace as normal. This was apparently incorrect. There does not appear to have been escalation from midwife to labour ward co-ordinator for fresh eyes review, nor escalation from midwife to consultant.

It is interesting to note that the root cause has been changed from "failure to expedite delivery at 11.10 and major placental abruption" to "incorrect assessment of CTG (human error) resulting in failure to deliver in a timely manner".

Action Plans with specific directives, time scales, evidence of achievement

There is evidence of an action plan with specific objectives, time scales and evidence of achievements. Action plans, except for on-going audit and staff CTG training with only 23% of staff compliant with the RCOG training package at time of incident, have been completed.

Incident discussed at appropriate meetings

The case was discussed at the perinatal and mortality meeting. The case was also for review by the Specialist Services Governance Group although this is dated the same time as the incident analysis was being written.

Evidence lessons have been learnt by midwives and medical staff

The case findings were published in 'Risky Business' but there is no evidence of wider learning.

Comments

The majority of recommendations in this report are focused on CTG training with extensive and thorough action plans. The RCA investigation report does not appear to have considered as an issue escalation to the on-call consultant when the midwife had concerns at 10.50hr about the CTG trace. Instead the registrar was bleeped at 11.15hr due to the presence of thick meconium, with registrar review not taking place until 11.30hr. There is no comment as to whether the midwife had serious concerns about the CTG and felt able to challenge the registrar when she/he wrongly classed the trace as normal. However, the assessors have been made aware that the on call consultant did review the CTG and made a plan of management. The midwife identified the CTG as suspicious throughout and escalated appropriately to the Registrar and the Consultant at the time. Escalation of concerns occurred.

8. REVIEW OF OTHER CASE RECORDS

To ascertain appropriate consultant presence on the delivery suite, the assessors requested access during the visit to the medical records of all cases of eclampsia, maternal collapse, caesarean section for major placenta praevia, massive obstetric haemorrhage, return to theatre for laparotomy that occurred on both sites during the Q3 and Q4 of 2014/15. Twenty-one sets of notes were available for review: severe pre-eclampsia six cases, major placenta praevia six cases, massive obstetric haemorrhage eight cases and one maternal collapse.

8.1 Severe Pre-Eclampsia

There were no eclamptic fits noted during the review. Consultant involvement was variable as was documented plans of care. There were differing views on whether an infusion of magnesium sulphate should continue during emergency transfers.

Case 1: There was good consultant involvement with a well-documented care plan. (QEQM site)

Case 2: This was a woman with a high risk pregnancy, monochorionc, monoamniotic twin pregnancy with severe pre-eclampsia at 33 weeks of gestation. Overall the medical entries were of poor quality and lacked an antenatal care plan. Consultant involvement could not be identified. The medical entries pertaining to the admission with severe pre-eclampsia were of poor quality and legibility. Status of doctors involved, other than doctors in training posts, could not be identified. (QEQM site)

Case 3: This case was well managed although some medical plans lacked clarity. The grade of medical staff involved could not be ascertained from the medical entries. (WH site)

Case 4: A 43 year old primigravida who presented at 17^{+3} weeks of gestation with raised blood pressure. There was no evidence of consultant involvement in the antenatal plan until 29 weeks of gestation when she was admitted to QEQM Hospital with severe pre-eclampsia. Due to capacity issues, an emergency (blue light) transfer between sites was required. The magnesium sulphate infusion was stopped during this

transfer. Up to transfer, there was no evidence of regular consultant ward rounds or involvement. Once arrived at WH Hospital, there was consultant involvement in her care with consultant present for the caesarean section delivery. There was evidence of on-going consultant involvement in the woman's postnatal care.

Case 5: A primigravida booked for care at WH Hospital but, due to capacity issues, was admitted to QEQM Hospital following spontaneous rupture of membranes. The woman was well managed but the grade of doctor involved could not be ascertained. Documentation quoted "unable to locate CTG monitor", *"and Dr ... always in office during everything"*. Minimal evidence of consultant involvement post-natally. There was a letter about another patient regarding anti- Kell antibodies filed in the records.

Case 6: This was a G4 P0 with essential hypertension who had booked at Darent Valley Hospital. She presented at 26^{+1} weeks gestation with severe pre-eclampsia and, following discussion with the consultant on-call at WH Hospital, was transferred as an emergency (blue light) on magnesium sulphate therapy. She was admitted to WH Hospital at 03.15hr and reviewed by a registrar. The consultant was phoned. The patient was seen by a consultant at 08.45hr and 13.30hr. Bloods and observations were abnormal and the patient had clonus. The next day no consultant review took place; there was a medical review but the grade of the doctor could not be identified and there was no thorough plan of care. On the following day, the patient was reviewed at 09.30hr and 12.15hr by both consultant and registrar with decision made for delivery that day. A good plan of care was made postnatally.

8.2 Major Placenta Praevia

The six cases reviewed had elective caesarean section deliveries with consultant presence for delivery. Antenatal care plans were of variable quality but steroid administration, blood product requirements and booking of interventional radiology were considered in all cases. Two cases lacked evidence of consultant involvement during the antenatal period. There was no consistency in standard of information given regarding risks and possible management options at the time of the operation. Two cases had a good postnatal plan documented, including a discussion on vaginal birth after caesarean section.

8.3 Maternal Collapse

A primigravida aged 42 years was initially booked for midwifery-led care. She was transferred to consultant care because of maternal age and a low lying placenta. Following an ultrasound scan examination at 34 weeks gestation, the placenta was found to be clear of the cervical os. She presented following spontaneous rupture of membranes at term at 02.30hr and was reviewed by the obstetric team at 09.10hr on the consultant ward round. The decision was made for augmentation of labour with no further medical review for 18.00hrs. She was then reviewed by a junior doctor who started syntocinon® and antibiotics for a pyrexia. The woman was cared for by a band 5 midwife overnight with no senior input or 'fresh eyes'.

The registrar was requested to review for failure to progress in the second stage of labour. The registrar was unavailable for a further hour. There was no evidence of escalation or consultant involvement.

After delivery the registrar left the patient with documentation *"had to leave to deal with another emergency"*, again no evidence of consultant escalation. The patient had sustained extensive perineal trauma and was left for a junior doctor to suture. Perineal repair took over 1hr 15 min with what appears to have been a gross underestimation of blood loss. When maternal collapse occurred 1hr 30 min later, the full team was called with consultant presence 27 minutes after maternal collapse.

The records were of poor quality with many non-contemporaneous entries, several duplicated photocopied sheets and loose sheets. There was an absence of medical review during labour augmentation and a failure

of escalation to the consultant when the registrar was unable to attend in the second stage. It was inappropriate to delegate to a junior trainee this difficult perineal repair with again a failure to escalate to consultant and request his/her presence.

8.4 Massive Obstetric Haemorrhage

Four cases followed caesarean section delivery, four after vaginal birth with recorded estimated blood loss of 600-6,000ml. There was little evidence of the use of a massive obstetric haemorrhage call with porters or haematology involvement. In seven cases, there were delays in escalation from the midwifery team to doctors and from midwives/middle grades to consultants. There was poor evidence of postnatal follow-up and debrief.

Case 1: This was an elective caesarean section at 39^{+2} weeks of gestation in a primigravida with a grade 2 placenta praevia. The consultant was present for delivery and the primary postpartum haemorrhage was effectively managed. The recorded estimated blood loss (EBL) was 600ml. (WH site)

Case 2: This primigravida spontaneously laboured at term with failure to progress in the second stage. The decision for caesarean section was made following a phone call to the on-call consultant at 03.57hr. The baby's head was $1/5^{th}$ palpable per abdomen and the positon was right occipito-transverse. Bladder damage was sustained during the caesarean section. Significant blood loss occurred. The consultant was called in to assist. The total recorded EBL was 2,700ml. (WH site)

Case 3: This primigravida laboured spontaneously at 35^{+5} weeks of gestation. The documentation throughout labour indicates a busy work load with no evidence of consultant support or presence. The following entries were made: *"Instrument trolley not available", "Not enough midwives to help", "had to leave after delivery for life threatening event"*. The woman required medical review at 20.00hr but the registrar only attended at 22.00hr with no documented evidence of escalation to the on-call consultant. A forceps delivery was performed at 22.07hr. The patient was taken to theatre at 01.00hr due to persistent vaginal bleeding and at this time the consultant was called in. The total recorded EBL was 3,000ml. (QEQM site)

Case 4: This G5 P3 woman in spontaneous labour gave birth at 06.32hr on the midwifery-led unit. The placenta was retained with patient transfer to the labour ward at 07.45hr. Registrar review took place at 08.37hr and at 09.30hr. There was no documented evidence of a consultant ward round and of consultant involvement. A syntocinon® infusion was commenced at 10.30hr. The documented blood loss was 1,300ml. The patient was taken to theatre at 11.30hr and by then EBL was 2,260ml. The consultant was called to theatre at 12.03hr. The total recorded EBL was 3,200ml. (WH site)

Case 5: This primigravid, non-English speaking woman, presented with a significant antepartum haemorrhage at 27 weeks gestation. The placental abruption was managed by the middle grade doctor with delivery by emergency caesarean section. There was no evidence of having informed the consultant. The total recorded EBL was 2,500ml. (WH site)

Case 6: This G2 P1 under midwifery-led care laboured spontaneously at term with a normal delivery at 02.03hr followed by a heavy vaginal blood loss. A junior doctor sited a cannula at 02.50hr. The registrar was not contacted until 03.15hr due to further bleeding. The EBL was 2,500ml. The consultant was contacted by phone but did not attend. (WH site)

Case 7: This G3 P2 under consultant-led care because of two previous caesarean section deliveries requested a vaginal birth. She presented in established labour and was seen by the SHO for CTG review. No

intravenous access was obtained. No senior obstetric review took place. Following a normal vaginal delivery, heavy bleeding was noted. At consultant review, the EBL was 1,850ml and the patient was transferred to theatre. The total EBL was 2,300ml. (QEQM site)

Case 8: This primigravida was admitted with pre-labour spontaneous rupture of membranes at 41 weeks gestation. Following discussion with the obstetrician, she was transferred to labour ward after 24 hours for induction of labour. A registrar review was requested due to CTG abnormalities. A decision was made by a locum registrar for a category 1 caesarean section delivery because of suspected fetal compromise. The consultant was aware but not present. The following day, the patient suffered a massive haemorrhage and returned to theatre twice. A Bakri balloon was inserted, 12 units of blood and blood products were required. She was admitted to the Intensive Care Unit. Following the massive postpartum haemorrhage, there was evidence of good consultant involvement and care plans. (WH site)

9. INTERVIEWS

By the nature of this review process, a significant amount of the information received is based on personal opinion. It is the role of the assessment team to ensure that when any findings are made, they are supported by a range of sources and do not present the views of individuals. For emphasis, direct quotations are sometimes used, but are set within a broader context

Terms of Reference (ToR) - To review the current provision of care within the Maternity Services in relation to national standards

How did the interviewee describe the department's standard of practice, supported by examples?

Across both sites, the department's standard of practice was perceived as being 'reasonable to good'. Trainees valued being on duty with their teams when on-call and found their educational supervisors very supportive. At the QEQM site, consultants practised in different ways and this could be difficult for trainees. Subspecialty services were offered on both sites although best practice was not always seen. The management of pregnant women with diabetes was repeatedly cited as an example of poor practice across sites. Standard of care given on both midwifery-led units was perceived as high with the core team sharing the same philosophy.

How did the interviewee think that the department keeps up to date?

The department used in-house meetings such as development and mandatory training days, audit and perinatal meetings as well as e-learning to keep up to date. The perinatal meetings held on Friday afternoons were seen as an opportunity to discuss interesting cases with good participation by attendees. Skills drills and CTG training sessions were reported as poorly attended by the consultant body. Trainees bringing new ideas from other units which kept seniors up to date.

How effectively does the department use national guidelines in the management of patients?

Both sites use the same guidelines. The 2014 Care Quality Commission Report of the Trust identified a number of clinical guidelines and policies as out of date. Obstetric guidelines have been updated mainly by midwives with little or no engagement from consultants. Guidelines are not recognised as important by some consultants, and they do not respond to guidelines sent out to them for comments. It was stated that some consultants do not follow guidelines. Consultants were reported as doing their own thing rather than follow guidelines. A RCA investigation may identify a need for a guideline revision but this task was either

never actioned or took many months to complete. There was a lack of audits to determine compliance with guidelines. There was no staff engagement in national audits. Some trainees used the RCOG or NICE guidelines as opposed to the Trust ones.

ToR - To review how serious incidents (SI) are identified, reported and investigated within the Maternity Services; how recommendations from investigations are acted upon by the Maternity Services and how processes ensure sharing of learning amongst clinical staff, board and senior management

Traditionally the level of SI reporting is low across both sites and relies on midwives to report. A trigger list can be found on the labour ward and on the Datix system. Incident reporting is left to midwives, doctors rarely report. SIs are sometimes identified at a perinatal meeting or by a paediatrician. A recent review of 368 unanticipated admissions to the neonatal unit across both sites last year identified 78 cases not reported, an average of 6.5 per month.

There is no cross-referring of incidents reported against information recorded on the maternity information system. To improve awareness and reporting, the on-call supervisor of midwives now contacts both sites at 07.00hr and 19.00hr to find out if any incidents have occurred. Community midwives are perceived as good at reporting incidents on Datix as they access Datix on their IPad at any time and place, not just from the constraints of hospital.

Band 7 midwives review Datix reported incidents and decide which incidents are to be investigated. The consultant body are not part of this and are not automatically notified of incidents. The clinical governance team meets weekly and reviews forwarded incidents. RCA investigations can take a long time to complete, with minimal consultant involvement. If poor consultant performance is identified in the course of a RCA investigation, this is not reflected in the action plans. There was a lack of performance management of the consultant body. Doctors would only be aware an investigation was taking place if personally involved.

Feedback on RCA investigations was given at clinical governance meetings, perinatal meetings and in the "Risky Business" newsletter. Interviewed staff seemed unaware that RCA investigation reports are circulated to all staff upon closure. Staff were aware that a drug incident automatically generates an e-mail distribution to all staff.

Where applicable, families are invited to come in and discuss the RCA investigation and are given a copy of the final report. However, all women should be informed when an investigation is taking place and offered the opportunity to be part of the investigation.

ToR- To review how the SI process links with the supervision process both internally and at LSA level and how supervision is managed for both student and registered midwives

Staff acknowledged delays with RCA investigations and the link between supervision and the SI process was not well articulated. SoMs had recently started to contact the units twice a day to ensure that incidents were reported to them. This enabled them to review the women's records to determine whether a supervisory investigation should take place. Supervisors were not always given time to undertake investigations which impacted on the timeliness and quality of the supervisory investigations. The SoMs reported that there was sometimes a delay in return of supervisory investigation reports from the LSA who could take 3 to 4 months to respond to queries. The view was that this delay in response was due to the excessive workload of the LSA.

ToR - To review the working culture within the Maternity Services including relationships and communication between midwives, trainees, obstetricians and neonatologists

How do doctors and midwives communicate with patients, each other and colleagues?

There did not appear to be problems with communication between staff and patients.

At the WH site, undermining, bullying amongst midwives and poor midwifery management had impacted significantly on the midwifery workforce but staff felt these issues were now resolved and there was a better atmosphere on the wards. Some midwifery staff expressed surprise at seeing suspended midwives back at work but there were no reports of further bullying as systems are now in place to prevent this. Staff were very supportive of the new Head of Midwifery.

At the WH site, consultant behaviour at meetings was perceived as disrespectful. This behaviour was tolerated by the consultant workforce and not recognised as a problem. This behaviour did not appear to impact on patient care as consultants respected each other's clinical decisions. Communication between trainees and consultants was good and the consultant body was a visible workforce on the labour site seven days a week.

At the QEQM site, the lack of a physical ward round on the labour ward and poor attendance, particularly at weekends, by three or four consultants contributed to delay in providing patient care.

On both sites, consultant teams worked in silos and, between sites, consultants did not interact. However, consultants on both sites wished to meet more frequently and to hold dedicated consultant business meetings. The Trust wide Perinatal Meeting for obstetricians, neonatologists and midwifery staff, held the second Friday afternoon of every fourth month was reported to the assessors as having poor obstetric consultant attendance. However, the assessors did not have sight of the attendance registers to confirm these reports.

There did not appear to be problems with communication between obstetricians and neonatologists. Cases were discussed on an ad hoc basis but with no regular meetings between fetal medicine leads and neonatologists on either site.

In the last GMC National Training Survey, trainees have reported bullying of trainees by midwives. Have you witnesses or heard of any such episodes?

Staff did not report having witnessed or heard of trainees being bullied by midwives and seemed surprised at the suggestion.

How does the department work as a team, using formal and informal mechanisms?

Teamwork at the QEQM site depended on the consultant on-call. It was felt there was no set standard for senior review, no post-take ward round and consultants had different opinions and changed plans of care.

On the other hand, teamwork at the WH site was perceived as good. Consultants would help colleagues with complex cases although the Clinical Lead was reported to be usually absent from the monthly consultant meetings.

On both sites, RCA investigations were led by midwives with minimal consultant involvement. If poor consultant performance was identified during an investigation, this was not reflected in the action plans. Incident reporting was left to midwives, doctors rarely reported a clinical incident.

In the interviewee's opinion, how does the department respond in an emergency?

Providing the emergency occurred during working hours with the consultant on site, the response to an emergency was perceived by interviewees as good. At the QEQM site, trainees, midwives and consultants reported that a lack of support was given by some consultants out of hours. There was a reluctance/refusal by these consultants to attend out of hours when requested. The assessors were not told of specific occasions when failure of consultant attendance lead to patient harm.

What, in the interviewee's opinion, are the department's strengths, supported by examples of good practice and good patient care?

On both sites, the co-located midwifery units were perceived as offering a good service to pregnant women.

The WH site was seen as a cohesive unit. Examples of strengths were the on-site presence of obstetric consultants, ten hours a day, seven days a week, giving good support to their trainees; the robust morning hand-over of care followed by a physical ward round when management plans were made and documented in the women's notes.

The QEQM site was seen as a friendly place with good communication between midwives.

What, in the interviewee's opinion, are the department's weakness, again supported by examples?

Both (WHH and QEQM) sites were perceived as offering poor facilities and a poor environment for labouring women, more so the WHH site. The co-located midwifery-led units on both sites were seen as offering the best facilities. Staff felt there should be elective caesarean section lists separate from emergency work at the QEQM site and commented on the distance to main theatres should access to a second theatre be urgently needed. Staff at the WH site also commented on the distance between main theatres and the maternity theatre.

The high sickness rate amongst hospital midwives, 8% at the WH site and 3% at the QEQM site, was thought to be a consequence of the recent midwifery upset, poor midwifery leadership with resulting disillusioned staff. There is a lack of specialist midwives including bereavement, diabetes and mental health midwives across both sites.

Out of hours, including weekends, were perceived as particularly vulnerable times due to patchy consultant presence at the QEQM site.

In the interviewee's opinion, are there any organisational issues which might contribute to the way the department performs?

The lack of a clear strategy at Trust Board level on the future of maternity services has led to low morale amongst staff who see no investment made into their maternity units. Staff believe maternity services are not on the priority list at Board level and that the previous Chief Executive was disengaged. However, the recently appointed Head of Midwifery is supportive of her staff and has secured an improved midwifery rota, more staffing and more equipment. The consultants at both sites felt they themselves did not communicate effectively with managers. One of the senior leads was not perceived as being equally supportive to both sites and followed their own agenda. The organisation was reluctant to trust consultants to run their own patch.

ToR - To identify any issues which may prevent staff raising patient safety concerns within the Trust

In the interviewee's opinion, are there any issues within the Trust which may prevent staff raising concerns about patient safety?

The majority of interviewees felt there was little point in raising concerns as there would be no action taken by the Trust.

If you had any concerns about patient safety, what would you do?

Staff were aware of how to report concerns. The existing culture was that consultants' practice was not challenged. Safety issues relating to practice were not reported as no action would be taken by the Leads.

ToR - To review the current obstetric consultant/middle grade workforce and staffing rotas in relation to safely delivering the current level of clinical activity and clinical governance responsibilities

Clinical governance meetings were poorly attended by the consultants. Only 50% attendance is required in their job plans. Trainees perceived the induction programme as poor and mandatory skills drills training did not form part of the induction.

Both sites had compliant middle grade and consultant rotas. The WH site offered 10 hours a day of consultant presence on site; the QEQM site offered 10 hours Monday to Friday and 5 hours on both Saturday and Sunday. However consultants were seen as more pro-active and more hands-on at the WH site. Historically, the QEQM site relied heavily on their SAS doctor workforce to run the labour ward and out of hours service provision. Traditionally consultants stay at home for their on-call although the current site lead is hoping to change this practice. Consultant presence on the labour ward will be monitored and an incident form completed when a consultant refuses to attend out of hours. Incidents have been reported in the past with no apparent action taken.

ToR - To review the education and supervision of obstetric middle grades and trainees including consultant accessibility and presence on the delivery suite as per RCOG recommendations in the context of providing a safe and efficient service

Poor clinical supervision of trainees by some consultants has been reported. In your opinion, are trainees supported by their consultants when working out of hours?

Trainees reported good supervision by their consultants at the WH site. At the QEQM site, trainees also reported good supervision by their consultants who were their educational supervisors. Following the poor ratings of the 2015 GMC National Training Survey on supervision, supportive environment and handover of care, the Site Lead and College Tutor with support from the Director of Medical Education have put measures in place to address these deficiencies. Trainees now get good support from trainers as their on-call consultant is their educational supervisor. This is evidenced by the positive comments from the trainees interviewed. Trainees are now allocated to consultants who provide training. The SAS doctors interviewed did not personally report problems with consultant accessibility out of hours but, by and large, these doctors requested little senior supervision. Some consultants reported their clinical workload did not allow time to teach trainees.

Other notable comments

What changes (if any) does the interviewee think would be appropriate to resolve issue(s) under consideration?

Staff were supportive of closer links between the two sites and felt this would help address the "them and us" current view of services with the QEQM site traditionally seen as the "poor relative". The practice of midwives and consultants working across sites would help facilitate this bond. Although the same guidelines and policies were in place, current clinical practices differed. Regular, more frequent meetings with improved consultant attendance and cross-cover working should improve the standard of care provision and may facilitate the development of specialist services such as outpatient hysteroscopy, diagnostic and treatment services.

The culture of tolerating lack of consultant presence on the delivery suite and non-attendance out-of-hours should cease and requires the implementation of punitive measures. Communication and working between teams would improve if there was less hierarchy amongst the consultant body.

Consultants felt job plans should be equitable and transparent with more recognised management time.

10. FINDINGS AND CRITICAL APPRAISAL OF EVIDENCE

Overview of current maternity services

ToR - To review the current provision of care within the Maternity Services in relation to national standards

Background:

Following their visit in March 2014, the Care Quality Commission (CQC) reported that most of the clinical guidelines for maternity were out of date. There was no timely process of review and revision for clinical guidance and standards. This task was not seen as a service priority. In their report, the CQC commented on how little the obstetric team were engaged with guideline development. As part of their action plan from the CQC findings, the Trust now has a database where guidelines are registered with review and expiry dates.

Findings from documentation provided by Trust and from interviews:

In East Kent's response to the CQC Special Measures Action Plan dated 9 July 2015, under "summary of urgent actions required" is listed that 'all paper and electronic policies, procedures and guidance are up to date and reflect evidence-based best practice' alongside progress as 'action having been achieved' and that staff can access these policies on SharePoint. The assessors were told by interviewees that the maternity guidelines were up to date. Assessors accessed SharePoint during their site visit and found this not to be the case. Some guidelines were long expired, for example 'Neonatal collapse' with a review date of October 2011, 'Severe pre-eclampsia', expired in July 2012. Whilst guidelines appear to have been up dated following the CQC visit, several bore inaccurate and old references, for example the 'Group B Streptococcus, prophylactic antibiotic treatment for women and management of babies' reference to NICE CG 149 should read 'Neonatal infection: antibiotics for prevention and treatment' and the guideline also referred to a now archived RCOG No.36 guideline from November 2003 and not to the revised version from July 2012.

The guideline co-ordinator expressed their frustration at both the lack of consultant involvement in the process of guideline review and revision and the time taken to revise an existing guideline. A full year is allowed for a review to occur and this is often extended. Despite sending the guideline author several

reminders, the 'Postpartum Haemorrhage' guideline, expired in April 2015, has yet to be updated on SharePoint.

Assessors were concerned that guideline revision is dependent upon a consultant informing the co-ordinator of a new guidance. This process does not happen consistently as the assessors read several guidelines that were not in agreement with current evidence-based best-practice. Two such examples were the 'Fetal heart rate monitoring' guideline which is not NICE 2014 compliant in its classification of fetal heart rate traces features and the 'Assessment of fetal growth restriction, detection and management', review date 18 June 2015, which is not in line with the RCOG Green-top guideline No.31, last revision January 2014, on the 'Investigation and Management of the small-for-gestational age fetus'.

The majority of obstetric guidelines were written by midwives with minimal input from obstetricians even when the guideline was an obstetric topic such as the 'Caesarean section' guideline. This is further evidence of the lack of obstetric engagement in guideline development.

The 2015 Trust policy for the 'Implementation of NICE Guidance and Quality Standards' states that *"when decisions are made not to implement NICE recommendations escalation to and approval from the Clinical Advisory Board should be gained"*. The assessors found no evidence this policy was being followed. The assessors were not told of any obstetric clinical audits against NICE guidance standards but were told of a current gap analysis comparing current practice in the management of pregnant women with diabetes against the recommendations of the NICE 2015 'Diabetes in Pregnancy' guidance. The Trust 'Diabetes in pregnancy' guideline states that it was *"amended in June 2015 to reflect NICE recommendations"*. This amended guideline does not reflect NICE recommendations. The guideline is not NICE compliant in many aspects – to name a few, pre-conception advice, timing of delivery, blood glucose targets, screening criteria for diagnosis of gestational diabetes and follow-up of women with gestational diabetes. It was concerning to hear that some clinicians used BMI≥ 35 as a screening risk factor even though their Trust guideline specifies BMI≥ 30.

Conclusion:

From the evidence provided, major clinical guidelines for maternity did not reflect current evidence-based best practice. Assuming clinical practice is to follow local guidelines, then current provision of care on both sites will not reflect best practice. The Baseline Assessment Tool for each NICE obstetric guideline can be used to identify non-compliance and then to base an action plan. Successful implementation requires the consultants to take ownership. Guidelines leads are necessary to co-ordinate but all obstetricians, trainees, SAS doctors and consultants need to play an active role. It is only recently that the Trust has sought evidence of compliance with NICE guidance. Clinical guidance and standards form an integral part of service provision.

Participation in National Audit Programmes where key indicators of performance and outcomes are measured helps units identify areas for improvement and ultimately improves the quality of care. The Trust does not participate in the National Pregnancy in Diabetes Audit (83% of consultant-led maternity units in England participated in the 2014 audit). Likewise, not all urogynaecologists enter their clinical data into the British Society of Urogynaecology (BSUG) national database. Participation in national audits should be compulsory unless the Trust has given permission for the department or individuals not to participate. Evidence of participation in national audits should be included in an individual's appraisal and results of national audits should be presented at Clinical Governance meetings.

ToR - To review how serious incidents (SI) are identified, reported and investigated within the Maternity Services; how recommendations from investigations are acted upon by the Maternity Services and how processes ensure sharing of learning amongst clinical staff, board and senior management

How are SI identified, reported, investigated and recommendations disseminated to staff?

Background

Serious incidents (SI) are reported by the organisation through the Strategic Executive Information System (STEIS). SI are also reported by the supervisory team to the Local Supervising Authority (LSA). In the Q3 /4 periods of 2014/15, East Kent Hospitals University Foundation Trust were the second highest reporter in the area, the majority of incidents falling into the "unexpected admissions to SCBU" category. The reasons for this are unclear and may be secondary to failings in care provision during the antenatal and/or intrapartum periods. It was also apparent that supervisory response to incidents was not as well evidenced on the LSA database compared with other Trusts. The LSA team have put measures in place to address this with support provided to the midwifery management and meetings with Supervisors of Midwives to help strengthen the links with clinical governance. Prompted by the concerns of the LSA Midwifery Officer, recommendations have been made for the Trust to provide assurance of safe and effective maternity care services through identification, investigation and learning from the management of serious incidents, effective links with supervisory processes with evidence of an active learning culture.

Findings from RCA Investigation Reports on 7 specific cases

The RCA Investigation reports followed the NPSA guidance. There was evidence of appropriate multidisciplinary involvement in the RCA investigations on the seven specific cases reviewed by the assessors. However, it was felt that Case 7 should have input from a consultant neonatologist and also from a midwife separate from the incident.

None of the cases reviewed were able to adhere to the "RCA Framework: Guide to Developing a RCA Report in 45 days" timescale of executive sign off by day 40-45 with 3 to 4 months being the average time.

The assessors felt that, in most cases, the investigation team focused on what they felt was the main contributory factor to the incident. Issues perceived as not being contributory factors were by and large not actioned. For example, Case 2 did not investigate the appropriateness of fetal heart rate monitoring during labour and delivery despite the baby suffering from grade 1 HIE. Likewise, in case 3, another case of HIE, the interpretation of the CTG trace and any required intervention was not part of the investigation, which focused on syntocinon® use.

The assessors felt that, in Case 1, the investigators did not approach the investigation from the woman's perspective and explore whether or not the outcome would have been different if she had been seen in a dedicated VBAC clinic, if a supervisor of midwives had been involved in her plan of care and if a plan of care had been made for her to labour on the midwifery-led unit. No recommendations were made to facilitate the care of a woman who wants to birth outside hospital policy.

Action plans had specific directives, time scales with evidence of achievements. Except for Case 5, all action plans show evidence of achievement in the reports.

It was felt by the assessors that midwifery practice issues and performance management were consistently well addressed. Case 6 used the NPSA Incident Decision Tree tool to help address a midwife's professional practice which helped ensure all aspects were covered in accordance with recommended guidelines.

Medical practice issues were inconsistently managed by the investigation teams. For example, Case 4 did not address the error of judgement made by the neonatal registrar nor was the obstetric registrar's failure to deliver a category 1 caesarean section within 30min addressed with that registrar. Case 5 identified practice issues with the anaesthetic registrar but no action plans, such as meeting with his/her educational supervisor, reflective practice and period of clinical supervision, were made in the recommendations to address his/her competence. Action plans did not feature notification to the Director of Medical Education when there was trainee involvement. Case 6 highlighted a failure of consultant review of an emergency obstetric admission yet this was not identified as a root cause by the investigators.

Some of the reports did not document whether or not women or their partners were aware of the investigation process, met with the team to discuss the findings or were offered a copy of the final RCA Investigation Report. Six out of seven incidents were discussed at a Perinatal Meeting. Presentations at the appropriate Trust Board meetings occurred and case findings were published in "Risky Business".

Findings from Interviews

It was apparent from the interviews that identification and reporting of incidents relied on individuals, with no system in place for cross-referring of incidents reported against information recorded on the maternity information system. A recent review of unanticipated admissions to the neonatal unit across both sites identified 78 out of 368 admissions as not having been reported. Midwives were perceived as being good at incident reporting, medical staff were not. Band 7 midwives reviewed reported incidents and decided whether or not to recommend investigation. The assessors felt this approach was too subjective with the temptation not to investigate incidents occurring on your own patch. Impartial person(s) should perform this task. If poor consultant performance was identified during a RCA investigation, this issue would not be reflected in the report's action plans. Although interviewed staff were aware RCA investigations could be found in the Risky Business newsletters and presentations were given at perinatal and clinical governance meetings, they were unaware that the reports were circulated to all upon closure. The perception was that only staff involved in the incident got a copy of the report findings and there was little evidence of wider learning across the two units.

Conclusion

For a RCA investigation to be of benefit, a multidisciplinary investigation team needs to address root causes, to challenge existing practice, to write a report with clear action plans, specific directives and time scales. Although time scales were not met, the other needs were by and large met from the reports read by the assessors. The main criticisms were the apparent failure to both address medical practice issues and make recommendations on issues perceived as not contributory to outcome by the investigating team. In particular, the investigation in Case 1 was a missed opportunity to make and implement recommendations to risk-assess complex care plans for women wanting to birth outside hospital policy.

ToR- To review how the SI process links with the supervision process both internally and at LSA level and how supervision is managed for both student and registered midwives

How are SI identified, reported, investigated and recommendations disseminated to staff?

Background

This has been described in the preceding ToR.

Findings from interviews

Supervisors of midwives are now more involved in the reporting of incidents. The on-call supervisor of midwives contacts both sites twice daily to find out if an incident has occurred and been reported. They were encouraged by the current Head of Midwifery to request extra hours for investigating and writing reports. It was acknowledged that there were delays in RCA investigations, some were attributed to difficulties in obtaining records and some to the LSA delayed response to queries. Interviewed student midwives had no issues with accessing and meeting with a supervisor of midwives. Other findings are described in the preceding ToR.

Conclusion

The assessors felt SoMs were getting more involved with the identification, reporting and investigation of SIs across both sites. This is a necessity as highlighted by reading the RCA investigation report Case 1, which fails to address both the lack of supervision involvement and how SoMs should offer guidance and support to women who wish to birth outside of hospital policy.

ToR - To review the current obstetric consultant/middle grade workforce and staffing rotas in relation to safely delivering the current level of clinical activity and clinical governance responsibilities

Background

The QEQM Hospital has just under 3000 births a year, 2235 in the obstetric-led maternity unit and 703 in the co-located midwifery led unit. There is 60 hours of consultant labour ward cover per week, 10 hours cover Monday to Friday (08.00hr to 18.00hr) and 5 hours cover on Saturday and Sunday (08.00hr to 13.00hr). The labour ward consultant also covers gynaecology emergencies.

The junior tier rota is a 1 in 9, the middle tier rota is a 1 in 8. The middle tier is currently staffed by 3 specialist trainees year 3-5, 1 LAS and 4 SAS doctors. One SAS doctor is on sick leave, another post is vacant and the unit is relying on locum middle grade cover. Weekday on-call cover is provided by 1 junior obstetrician and 1 junior gynaecologist, 1 registrar covering obstetrics and gynaecology plus the consultant on-call. Weekday night and weekend cover is provided by 1 junior, 1 registrar and 1 consultant covering obstetrics and gynaecology. The consultants (1 in 8 on call) have a set day on-call with their junior team.

The WH Hospital has just under 4000 births a year, 3268 in the obstetric-led maternity unit and 656 in the co-located midwifery led unit. There is 70 hours of consultant labour ward cover per week, 10 hours cover Monday to Sunday (08.00hr to 18.00hr). The labour ward consultant also covers gynaecology emergencies. The junior and middle tier rota are a 1 in 8. The middle tier is currently staffed by three specialist trainees year 3-5, 1.3 ST 6-7 (job share), 2 SAS doctors, 1 MTI and 1 Trust doctor. Weekday on-call cover is provided by 1 junior obstetrician and 1 junior gynaecologist, 1 registrar covering obstetrics and gynaecology plus the consultant on-call. Weekday night and weekend cover is provided by 1 junior, 1 registrar and 1 consultant covering obstetrics and gynaecology. The consultants (1 in 9 on call) have a set day on call with their junior team.

Both maternity units have one dedicated operating theatre for obstetrics. There are three dedicated elective CS lists (maximum three cases) a week at the WH Hospital, which take place in the maternity theatre. There is no dedicated "back-up" theatre in either unit.

Findings from documentation provided by Trust and from interviews

The guideline 'Consultant Obstetricians: Referral to and attendance on labour ward when on call', date issued March 2015, details the duties of the on-call consultant on labour ward. It states a minimum of a

formal hand-over at 08.00hr from the night on-call team in the presence of the labour ward co-ordinator followed by review of all high risk women, including inductions of labour, with documentation in the women's notes of the management plan written by either registrar and countersigned by the consultant or written by the consultant.

At 13.00hr, a labour ward board review should take place with the co-ordinator followed by review of high risk women and review of management plans. Any new high risk admissions should be seen.

At 18.00hr, a labour ward round of high risk women is to be carried out with documentation in the women's notes.

At 22.00hr, the registrar should call the consultant on-call for a telephone review of all women. The situations where attendance in person of the consultant is expected, regardless of level of trainee, is in accordance with the *RCOG Good Practice guideline No.8 'Responsibility of Consultant on-call'*, March 2008.

At the WH site, all obstetric consultants participated actively on the labour ward during their ten hour shift, seven days a week as evidenced by the interviews. Consultant attendance for labour ward rounds was in accordance to the Trust guideline 'Consultant Obstetricians: Referral to and attendance on labour ward when on call' with review and management plans made. If necessary, consultants stayed on site beyond their ten hours shift. They attended the unit when requested to out of hours.

At the QEQM site, interviews revealed a different standard of practice. Whilst there were consultants at that site that followed the above named Trust guideline, there were three to four consultants who consistently failed to do so. This practice is long-standing. Patient harm may have been mitigated as the QEQM maternity unit is a small unit and these consultants are on-call with SAS doctors, usually more experienced doctors than junior specialist trainees. This unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants.

Findings from review of case records

To help ascertain appropriate consultant presence on the delivery suite, the assessors requested access during the visit to the medical records of all cases of eclampsia, maternal collapse, caesarean section for major placenta praevia, massive obstetric haemorrhage, return to theatre for laparotomy that occurred on both sites during the Q3 and Q4 of 2014/15. Twenty-one sets of notes were available for review: severe pre-eclampsia 6 cases, major placenta praevia 6 cases, massive obstetric haemorrhage 8 cases and 1 maternal collapse.

The general themes identified were:

- Record keeping

Midwives document their pay band as an integral part of record keeping and on the records reviewed appear to follow a hierarchical approach through the senior midwife before referral to obstetric teams. Midwifery record keeping was generally of a good standard and it was easy to identify the midwife.

The entries made by doctors in training were of a higher standard than consultant or SAS doctors with regards to legibility, use of registered name and GMC number. Many of the cases reviewed had significant amounts of retrospective note entry with a rationale of being busy.

- Teamwork and escalation

There was some evidence of good multidisciplinary working. Plans of care were made but this appeared to be person-specific rather than standard. Several entries reported the need to leave for conflicting emergencies but there was no evidence of escalation by either doctor or midwife to the consultant. It was not possible for the assessors to draw any conclusion regarding individual practice or areas for concern. There was little evidence of the 'fresh eye's approach in managing complex cases.

- Consultant presence on the delivery suite

None of the cases reviewed support the verbal reports the assessors heard, regarding the ten hour consultant presence on the labour ward or a consultant-led ward round at 08.00hr with review of high-risk women at 13.00hr and 18.00hr.

- Facilities

Some records documented a lack of available equipment.

- Filing in medical records

In general filing was of a very poor quality. There were several examples of loose filing and in one case a letter regarding an antibodies result belonging to another patient was found. The assessors actioned and escalated this at the time of the visit.

Conclusion

At both sites, the obstetric staffing rota is compliant on paper with the obstetric staffing levels recommendations made in the *'2007 Safer Childbirth: Minimum Standards for the Organisation and Delivery of care in Labour Report'*[2]

According to job plans, the QEQM Hospital provides a minimum of 60 hours of consultant labour ward presence per week as they have under 3000 births per year and the WH Hospital a minimum of 70 hours presence per week for under 4000 births per year. As occurs in the majority of such sized units, the labour ward consultant also covers emergency gynaecology. The impression from listening to interviewees was that the ten hour consultant presence and the three times daily ward rounds took place at the WH site. However, the review of medical records of cases of severe pre-eclampsia, maternal collapse, caesarean section for major placenta praevia and massive obstetric haemorrhage, and return to theatre for laparotomy does not support this impression.

Interviews revealed significant concerns about the failure of three to four consultants on the QEQM site to conduct daily labour ward rounds, review women, make plans of care and attend when requested out of hours. It is the assessors' understanding that, across both sites, consultant compliance with the Trust guideline *"Consultant Obstetricians: Referral to and attendance on labour ward when on call"* is going to be monitored. It is the opinion of the assessors that failure to comply with the guidelines' consultant duty of care should prompt the Medical Director to instigate a formal investigation into conduct allegations in line

[2] Safer Childbirth, Minimum standards for the organisation and delivery of care in labour. RCOG 2007

with the Trust's procedure for dealing with conduct, capability and health issues for medical and dental staff.

ToR - To review the education and supervision of obstetric middle grades and trainees including consultant accessibility and presence on the delivery suite as per RCOG recommendations in the context of providing a safe and efficient service

Background

The 2015 GMC National Training Survey highlighted 'below outliers' in the specialty of obstetrics and gynaecology at QEQM Hospital for the following indicators:

- overall satisfaction (mean=68.0, national mean=78.81) ,
- clinical supervision out of hours (mean=81.54, national mean=89.25),
- handover (mean=67.71, national mean=87.97),
- induction (mean=71.92, national mean=85.71) and
- study leave (mean=46.21, national mean=68.83).

WH Hospital had no below outlier scores and scored above the IQR3 in the indicator supportive environment (mean=81.25, national mean=71.48). WH Hospital was in the IQR1 but not a below outlier for induction of trainees.

Findings from interviews

The assessors interviewed four specialist trainees, three SAS doctors, the College Tutor from each site, the Director of Medical Education and, by phone, the Head of School for East Kent, Sussex and Surrey Local education and training boards (LETB).

The Head of School voiced that no issues had been raised by trainees at LETB level and that vacant trainee posts were due to the geography of the units as opposed to a poor standard of training being offered. Overall, the interviewed trainees felt supported on both sites despite marked differences between the sites in consultant presence both during and out of working hours. Trainees were on-call with their team and their consultant was their educational supervisor. The trainees were very positive about their educational supervisor. The junior trainees on both sites reported problems with clinical supervision at weekends, especially daytime, as they covered both obstetrics and gynaecology.

The absence of consultant input at QEQM during weekends caused increased pressures to trainees. Trainees felt electronic handover (computerised) had improved patient care.

Trainees on both sites commented negatively about their induction. Mandatory skills drills training is not part of their induction programme. Due to their rota structure, trainees found it difficult to attend teaching on Friday afternoons at the QEQM site. No trainee reported difficulty with being granted study leave.

Conclusion

Both College Tutors with support from the Director of Medical Education and the site lead at QEQM have put in place measures to improve the education and supervision of trainees in obstetrics and gynaecology. The trainees work with their educational supervisors and only consultants committed to teaching and to supervision become educational supervisors. There is recognition in the new consultant job plans for this role. The assessors are concerned that this practice will result in consultants not committed to teaching and

supervision to be on-call with a locum middle grade doctor (only two out of four SAS doctors currently in post), potentially of unknown competence, which could impact on safety of care in the maternity unit.

There are plans to change the in-housing teaching day to improve junior attendance. Both sites need to review their induction programme as this is still reported as in need of improvement by interviewed trainees.

ToR - To review the working culture within the Maternity Services including relationships and communication between midwives, trainees, obstetricians and neonatologists.

The assessors felt that the issues of undermining and bullying amongst midwives at the WH site had now been addressed and resolved. Even when on-going, these issues did not appear to affect patient care and were confined to the midwifery circle as evidenced by the consultant obstetricians at the WH site being unaware of their existence. Midwifery staff felt there was a better atmosphere on the wards now, better midwifery leadership and staff were supportive of the new Head of Midwifery and management structure.

Trainees from both sites reported good working relationships with midwives and obstetricians. Teamwork at the WH site was on the whole perceived as good although teams tended to function as individual teams with little interaction between teams. Teamwork at the QEQM site was of a variable standard depending on the consultant on-call. There was little consultant interaction across sites despite interviewed consultants wishing for more interaction.

At each site, communication between obstetricians and neonatologists occurred on a case-by-case basis and was perceived as good.

The assessors recommend consistency across teams on both sites with regards to on-call care provision, ward rounds and activity of on-call consultant. It was felt that the consultant body should be more respectful and supportive of each other as individuals. Consultants should aspire to work together between two sites that are part of one Trust. Joint working, at both midwifery and obstetric levels, with centralisation of subspecialty services would ultimately strengthen both maternity units.

ToR - To identify any issues which may prevent staff raising patient safety concerns within the Trust
Background

Concerns relating to consultant presence at operations and on the labour ward interlink with quality of care provision and patient safety. An internal investigation into allegations of bullying amongst midwifery staff at the WH Hospital led to temporary staff suspension followed by re-instatement. The Trust's Raising Concerns (whistleblowing) policy and procedure was updated in November 2014 following the CQC report and a review by internal audit.

Findings from interviews

The assessors repeatedly heard medical and midwifery staff working on both sites say there was no point in reporting safety issues as no action would be taken by the Trust. The "whistle-blower" was made to feel unsupported by managers and got minimal/no feedback to concerns raised. When concerns were raised about the communication skills and competence of a consultant, an investigation was held. At the end of this investigation, the consultant was given staff statements and allegedly confronted individual staff. This behaviour was allowed by the Trust without sanctions.

The assessors were told by a consultant that a junior doctor had reported concerns about a consultant's laparoscopy technique but no investigation took place as the doctor did not want to express his concerns in writing. Staff seemed to accept their concerns not being resolved within the Trust structure and did not appear to escalate concerns externally. A "Shout out for Safety" site for raising concerns has recently been put on the Trust website but staff had no knowledge of this site.

Conclusion

The assessors are concerned that staff on both sites are no longer raising concerns about unsafe practices, conduct or performance of colleagues which affects patient safety or care because this has been done in the past without satisfactory resolution and with harassment of staff. Staff reluctance to raise concerns appears to exist across all specialties in the Trust. The Trust should raise awareness amongst staff of the process flowchart for raising concerns, the need to go beyond the line managers and to escalate to Trust Board level and even externally to a regulator or other external body such as NHS Protect, NHS England, GMC or Nursing and Midwifery Council. A list of external contacts can be found in the 2014 Trust's *"Raising Concerns (Whistleblowing) Policy and Protocol"*. The Trust should promote a culture of openness and transparency where staff are encouraged to raise concerns without fear of reprisal or victimisation.

11. CONCLUSIONS

Strengths of the maternity services

- MBRRACE-UK perinatal mortality report for births in 2013 reported a stillbirth rate more than 10% lower than the average for similar trusts, neonatal death rate up to 10% lower than average, extended perinatal death rate more than 10% lower than average.
- RCOG Clinical Indicators Project for Maternity for the period 2013/14 had no outliers at the WH site and only two outliers for 18 indicators at the QEQM site - caesarean section rate 25.8% (national mean 22.3%) and maternal hospital readmissions within 42 days of delivery 3.9 (national mean 1.9%).
- Co-located midwifery-led units on both sites
- Recent management restructure with new Head of Midwifery.

Weaknesses of the maternity services

- Inconsistency in consultant ward rounds on labour ward at both sites, more apparent at the QEQM site.
- Inconsistency in consultant duties at weekends, job plans requiring ten hours each weekend day at the WH site and five hours each weekend day at the QEQM site, more apparent at the QEQM site.
- Vulnerable QEQM unit out of hours: reluctance/non-attendance of on-call consultants (3 to 4) to attend unit when requested.
- Maternity guidelines are midwifery-led with poor consultant participation in writing and revision of them.
- Lack of engagement in national audits.

- Induction programme on both sites poorly evaluated by the trainee doctors.
- Poor labour ward facilities and environment on both sites.
- Lack of dedicated elective caesarean section lists at the QEQM site.
- High midwifery sickness rate across both sites.

12. RECOMMENDATIONS

ToR - To review the current provision of care within the Maternity Services in relation to national standards

1. Clinical guidelines need to reflect current evidence-based best practice and national guidance. If a guideline is non-compliant with NICE guidance, Trust policy with escalation to the Clinical Advisory Board should be followed.

2. A system should be in place to ensure guideline review and revision occurs in a timely fashion when new national guidance is published. Important changes to fetal heart monitoring and assessment of fetal growth restriction, published in 2014 and 2013 respectively, have not been incorporated into the Trust's local guidelines with no apparent plans for revision.

3. Multidisciplinary engagement should be encouraged in the writing of clinical guidelines.

4. There is a lack of medical (consultant, SAS doctors and trainees) engagement in guideline development. Obstetric guidelines are written predominantly by midwives.

5. The Trust should participate in the National Pregnancy in Diabetes Audit as the resulting benchmarking exercise would identify areas for improvement and ultimately improve quality of care. All urogynaecologists should enter their pre-, intra- and postoperative data relating to any incontinence and/or prolapse procedure into the BSUG national database. This data should form part of the consultant's personal development and appraisal.

ToR - To review how serious incidents (SI) are identified, reported and investigated within the Maternity Services; how recommendations from investigations are acted upon by the Maternity Services and how processes ensure sharing of learning amongst clinical staff, board and senior management

6. A system should be in place to ensure all incidents are reported and appropriately actioned. Compliance with this should be audited on a regular basis, with data taken into consideration with that collected on the maternity information system.

7. If practice issues and performance management of medical staff, including consultants, are identified as root causes and/or contributory factors, these should be addressed in the timeline with the recommendations and action plans.

8. The Clinical Governance team should ensure that final reports are circulated to all staff. Evidence obtained from interviews suggests that shared learning from action plans depended on staff either

attending a SI presentation at a perinatal morbidity/mortality meeting and/or accessing the Risky Business newsletter.

ToR - To review how the SI process links with the supervision process both internally and at LSA level and how supervision is managed for both student and registered midwives

9. Supervisors of Midwives should undertake regular audits of their twice-daily phone calls to both units made to identify reported incidents. SoMs should be given appropriate time from their clinical duties to undertake supervisory investigations with support from the LSA in a timely manner.

10. Cross-referencing of incidents against data entered electronically on the maternity information system should be undertaken by the clinical governance team.

11. If the non-adherence to the 45 days' timescale for submission of RCA Reports to Kent and Medway Commissioning Support and other external agencies as appropriate is to be addressed, the Trust needs to ascertain at what point in the investigation the delays are occurring.

ToR - To review the current obstetric consultant/middle grade workforce and staffing rotas in relation to safely delivering the current level of clinical activity and clinical governance responsibilities

12. All medical staff should be reminded of their legal responsibility to legibly date and sign each entry along with a printed signature and their GMC registration number.

13. An audit of compliance with the local guideline *'Consultant Obstetricians: Referral to and attendance on Labour Ward when on-call'* may identify poor practice and improve care provision.

ToR - To review the education and supervision of obstetric middle grades and trainees including consultant accessibility and presence on the delivery suite as per RCOG recommendations in the context of providing a safe and efficient service

14. The Trust needs to improve their induction programme for Specialist Trainees in Obstetrics and Gynaecology and to include obstetric skills drills training into the programme.

15. The College Tutor and Site Lead should ensure the in-house Friday afternoon teaching is held at another time to facilitate trainees' attendance. Trainees at the QEQM site find it difficult to attend due to rotas.

16. Compare the frequency of SUI's out of hours between consultants on call with SAS doctors and consultants on-call with trainees. The Trust has addressed the poor ratings from the 2015 GMC National Training Survey by placing trainees at the QEQM site with consultants committed to teaching and supervision. The assessors are concerned that doing this does not address the root cause. Furthermore, the QEQM site remains vulnerable as consultants not committed to teaching and supervision are now on call with locum middle grade doctors with only 2 out of 4 SAS doctors are currently at work.

17. Failure to comply with the guidelines *'consultant duty of care'* should prompt the Medical Director to instigate a formal investigation into conduct allegations in line with the Trust's procedure for dealing with conduct, capability and health issues for medical and dental staff. To-date, poor consultant behaviour regarding lack of accessibility and presence on the delivery suite has not been challenged by management. Plans are that consultant presence will be monitored on both sites.

18. The RCOG e-learning Strat OG resources on "Communication Skills" and "Improving Workplace Behaviour" should be accessed by all consultants and especially the ones identified as having problems with education and supervision of trainees.

ToR - To review the working culture within the Maternity Services including relationships and communication between midwives, trainees, obstetricians and neonatologists

19. Interpersonal, teamwork and communication courses may enhance communication and respect between consultants. Evidence obtained from interviews points to behavioural issues concerning relationships between consultants.

20. Consultants and midwives should aspire to work together between two sites that are part of one Trust. Joint working, enabling centralisation of subspecialty services and development of services, would ultimately strengthen both maternity units.

ToR - To identify any issues which may prevent staff raising patient safety concerns within the Trust

21. Address the current belief in the futility of raising concerns amongst staff by discussing the Trust's Raising Concerns (whistleblowing) Policy and Procedure at Specialty and Clinical Governance meetings, Senior Midwives meetings and Supervisors of Midwives Forum.

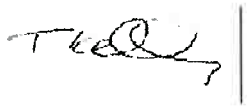
22. Promote a culture of raising concerns without blame amongst staff by awareness and feedback events organised by the Executive Team across specialties.

23. Identify a named Executive Director in the Trust's Raising Concerns (whistleblowing) Policy and Procedure so that staff who feel unable to raise concerns or fail to achieve a satisfactory outcome with their line manager are aware of whom to contact.

13. SIGNATURES

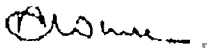
In formulating and signing this report we confirm that our conclusions and recommendations are based solely on the information provided to us, and on interviews that took place during the assessment visit described. We also certify that we have no prior knowledge of the individuals concerned, and have not worked previously with them. We have no relevant conflicts of interest to declare in respect of these matters.

Dr Claire Candelier Date 15 February 2016

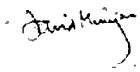


Dr Teresa Kelly Date 15 February 2016

Joy Kirby Date 15 February 2016



Alison Whitham Date 15 February 2016



Dr David Milligan Date 15 February 2016

14. Appendix

1. Speciality Document Queen Elizabeth Queen Mother Hospital

RCOG SPECIALITY DEPARTMENT VISIT
Queen Elizabeth Queen Mother Hospital

Please can the Departmental leads complete this questionnaire, which will give concise background information, and return to the lead assessor or the review two weeks before visit

Please attach diagrams of departmental management structure, meetings and flow of reporting. Also dashboard of clinical activity – **please note, these are all available in the folder of evidence provided**

Medical staffing:

Consultants	WTE (total number)	Junior staff/trainees	WTE (total number)
Obstetric only	-	FY2	2
Gynae only	2 - oncology	GP ST	4
Combined	8.75	ST 1 / 2	1
		ST3 – 5	3
Labour ward lead	Graham Ross	ST 6 / 7	0
Fetal medicine lead	Graham Ross	Permanent speciality	4
Gynae lead	Graham Ross (CL)	Long term locum 2xST1 LAS, 1xCF	3
Trust Oncology lead	Andy Nordin	Others – please specify	
Colposcopy lead	Andy Nordin	FY1	1 (not on rota)
Other leads Urogynaecology	John Shervington		
GAU/EPU	Zoe Woodward		
Rapid Access	Ike Okorocha		
Trust Sub Fertility	Anastasia Goumenou		
Trust Minimal Access Lead	Martin Farrugia		

How many hours of Consultant labour ward cover / week? 60

Does Consultant on call/LW also cover gynae? YES

Junior tier rota: 1 in .....9. Banding: .....1A.....

Middle tier rota: 1 in .....8. Banding: .....1A.....

Third tier (if applicable) rota: 1 in .....N/A. **Banding:** .....N/A.....

Who is on third tier live in rota? N/A

If a Consultant – is there another Consultant on call from home? NO

Number of live in Doctors on call

Eg Weekday	*1 registrar obstetrics* *1 registrar gynae*	*1 junior obstetrics* *1 junior gynae*
Weekday	1 Consultant obs/gynae 8am-6pm 1 Registrar obs/gynae	1 junior obs 1 junior gynae 8am-5pm
Weekday night	1 Registrar obs/gynae	1 junior obs/gynae
Weekend day	1 Consultant obs gynae 0800-1300 1 Registrar obs/gynae	1 junior obs/gynae
Weekend night	1 registrar obs/gynae	1 junior obs/gynae

Times of on call handover: 0800-0830 20.00-20.30 17.30-18.00 Consultants round

Is there a specific Consultant to do antenatal ward round on weekdays? NO

Is there a gynae Consultant on call with no other routine duties? NO

Who does the gynae ward round? The on call team. Also dedicated gynaecology WR on Saturday and Sunday

Midwifery:

Head of Midwifery:	Helen Bland
Deputy Head of Midwifery:	Vacant – to be advertised as Deputy recently appointed to Head
How many senior Midwives & roles? WHOLE TRUST – cross site working takes place	(Band 8) – 6 3 Matrons (2 acute site, 1 community) 1 Practice Development 2 Consultant Midwives (1 normality, 1 public health)
How many Supervisors of Midwives:	25 (5 on leave of absence).
Midwife : Birth ratio	Average per year : 1:28.8

Management:

SDU Lead (name)	Clinical Lead : Kate Neales
Governance Lead:	Michelle Burrough (Matron) John Seaton (Obstetrics/Gynaecology)
Obstetrician	Kate Neales
Midwifery	Helen Bland
Gynaecologist	Kate Neales
Departmental managers: Numbers and roles:	1 Acute site Matron 1 labour ward lead 1 postnatal ward lead 1 MLU lead 1 Fetal medicine/Day care lead

List departmental management / clinical meetings:

Meeting	Who attends	Frequency	Reports to:
Eg: Perinatal morbidity	*All Obstetricians & Neonatologists*	*1st Tuesday lunchtime of month*	*SDU business meeting*
Perinatal mortality meeting – site based	Obstetricians, neonatologists, midwifery staff	Second Friday afternoon of 3 out of 4 months	Risk Process/Corporate Governance Team
Perinatal meeting - Trustwide	Obstetricians, neonatologists, midwifery staff	Second Friday afternoon of every 4th month	Risk Process/Corporate Governance Team
Labour ward forum	Labour ward lead, midwifery lead, anaesthetist, midwives, obstetricians	Bi-Monthly	
CTG meetings	All available staff	Weekly Thursday lunchtime	
Specialty teaching	O&G Specialist trainees	Friday afternoons except Wk 2	College Tutor
CQUINS Term admission to SCBU meeting	Neonatology, labour ward lead, governance	Every Wednesday	CQUINS project lead
Unit meetings	Midwives – separate meetings for all bands , also support staff	Monthly	Midwifery management team
Midwifery management meetings	HOM, Band 8's	Bi-weekly	Leadership team
Procurement meeting	HOM, Matron	Monthly	Senior Management team
Senior Management Team Meeting	Obstetric Clinical Leads, Service Managers, HOM, Matrons, HR Business Partner, Finance Mgr	Monthly	

Gynaecology meetings not included			

Clinical Governance Structure:

Allocated Managers:
Kate Neales (Clinical Lead) John Seaton (Risk Lead), God'swill Etokowo (Audit Lead), Jo Olagboyega (Clinical Governance/Patient Safety Midwife), Michelle Burrough (Divisional Clinical Governance Matron), Anne Heseltine (Guideline Lead)

List meeting structure	List pathway of an incident report
Weekly incident review : Obstetrician Governance Lead, Midwifery Governance Lead, Supervisor of midwives	Review of incident, checking of severity, checking of immediate action taken, grading alteration as required, notes reviewed as necessary. If SUI RCA or AAR decided upon and set up following discussion with corporate risk team
Monthly clinical governance meeting (Women's Health Clinical Governance Forum)	Wider review of governance structures, risk register, complaints, audit, training, anaesthetic, neonatal and VTE attendance and review of individual incidents/RCAs
Monthly governance/audit meeting shut down day	Presentation of RCAs, presentation of completed audits. Takes place on a "shutdown day" off site; all medical staff (except those on call) expected to attend
Specialist Services Divisional Governance Board Meeting	Exception reports and incidents discussed at divisional level

Do the trainees attend a clinical governance meeting?
YES – The bi-monthly governance/audit clinical shutdown day; they can attend the monthly clinical governance meeting if they wish – invitation sent in 'Risky Business' and staff newsletter.

If not – how do lessons learnt get disseminated to medical staff?

In addition –'Risky Business' newsletter. Also trust wide circulated 'Risk Wise' from corporate risk team and 'learning from complaints' newsletter circulated from the Patient Experience Team. RCA's are circulated to all staff upon CCG closure. If guidelines are changed as a result of lessons learnt, emails are circulated to staff. Skills drills training where the programme is enhanced regularly according to lessons learnt.

To midwifery staff: as above, and in addition, 2 annual mandatory midwifery study days where the programme is altered depending on action plans resulting from RCA's. Also through feedback from community midwifery and unit meetings and through Supervision annual review

Beds / Activity:

Number of beds / rooms:		
Labour Ward	7 Delivery rooms 1 Pool room 3 induction beds	
Triage	None	
Obs / HDU on labour ward	None	
Antenatal & postnatal	22	
Stand-alone birth centre	No	
On-site birth centre	Yes – 4 rooms including 2 pool rooms	
Gynae ward	15 funded and 4 contingency beds	
Number of staffed labour ward only theatres		(insert hours)
Weekdays	1	24 (includes elective LSCS lists)
Out of hours	1	24

RCOG SPECIALITY DEPARTMENT VISIT
William Harvey Hospital

Please can the Departmental leads complete this questionnaire, which will give concise background information, and return to the lead assessor or the review two weeks before visit

Please attach diagrams of departmental management structure, meetings and flow of reporting. Also dashboard of clinical activity –**please note, this information is all contained within the folder of evidence sent**

Medical staffing:

Consultants	WTE (total number)	Junior staff/trainees	WTE (total number)
Obstetric only	-	FY2	2
Gynae only	-	GP ST	3
Combined	8 + 1 (Associate Specialist acting consultant)	ST 1 / 2	3
		ST3 – 5	3
Labour ward lead	Choy Lee	ST 6 / 7	1.3 (job share)
Fetal medicine lead	Sarah Chissell	Permanent speciality	2
Gynae lead	Kate Neales (CL)	Long term locum	
Oncology lead	Andy Nordin	Others – please specify	
Colposcopy lead	Niyi Agboola	MT1 Trainee	1
Other leads		LAS – Trust Dr	1
EPU/GAU	Abhijeet Shah		
Urogynaecology	Brian Wise		

How many hours of Consultant labour ward cover / week? 70

Does Consultant on call/LW also cover gynae? YES

Junior tier rota: 1 in .....8. Banding: .....1A.....

Middle tier rota: 1 in ...8.... Banding: .....1A.....

Third tier (if applicable) rota: 1 in ...n/a.... Banding: .....n/a.....

Who is on third tier live in rota? N/A
If a Consultant – is there another Consultant on call from home? NO

Number of live in Doctors on call

Eg Weekday	*1 registrar obstetrics* *1 registrar gynae*	*1 junior obstetrics* *1 junior gynae*
Weekday	1 Consultant obs/gynae 8am-6pm 1 Registrar obs/gynae	1 junior obs/gynae 1 Junior gynae from 1300-1700
Weekday night	1 Registrar obs/gynae	1 junior obs/gynae
Weekend day	1 Consultant obs gynae 8am-6pm 1 Registrar obs/gynae	1 junior obs/gynae
Weekend night	1 registrar obs/gynae	1 junior obs/gynae

Times of on call handover: 0800-0830 1300 1800 if applicable

Is there a specific Consultant to do antenatal ward round on weekdays? NO

Is there a gynae Consultant on call with no other routine duties? NO

Who does the gynae ward round? Individual teams see their own patients. The on call team sees the emergency take patients.

Midwifery:

Head of Midwifery:	Helen Bland
Deputy Head of Midwifery:	Vacant – to be advertised as Deputy recently appointed to Head
How many senior Midwives & roles? WHOLE TRUST – cross site working takes place	(Band 8) – 6 3 Matrons (2 acute site, 1 community) 1 Practice Development 2 Consultant Midwives (1 normality, 1 public health)
How many Supervisors of Midwives:	25 (5 on leave of absence).
Midwife : Birth ratio	Average per year : 1:28.8

Management:

SDU Lead (name)	Clinical Lead : Kate Neales
Governance Lead:	Michelle Burrough (Matron); John Seaton (Obstetrics/Gynaecology)
Obstetrician	Kate Neales – overall lead
Midwifery	Helen Bland
Gynaecologist	Kate Neales – overall lead
Departmental managers: Numbers and roles:	1 Acute site Matron 1 labour ward lead 1 postnatal ward lead 1 MLU lead

	1 Fetal medicine/Day care lead

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Perinatal meeting - Trustwide	Obstetricians, neonatologists, midwifery staff	Second Friday afternoon of every 4th month	Risk Process/Corporate Governance Team
Labour ward forum	Labour ward lead, midwifery lead, anaesthetist, midwives, obstetricians, neonatologist	Once every two months on Tuesday afternoon	
Guideline Group	Midwife, obstetrician	Second Friday morning monthly	
CQUINS Term admission to SCBU meeting	Neonatology, labour ward lead, governance	Every Wednesday	CQUINS project lead
CTG review meeting	Obstetricians, midwives	Weekly	
Unit meetings	Midwives – separate meetings for all bands. Also support staff	Monthly	Midwifery management team
Midwifery management meetings	HOM, Band 8's	Bi-weekly	Leadership team
Procurement meeting	HOM, Matron	Monthly	Senior Management team
Senior Management Team Meeting	Obstetric Clinical Leads, Service Managers, HOM, Matrons, HR Business Partner, Finance Mgr	Monthly	
Gynaecology meetings not included			

Clinical Governance Structure:

Allocated Managers:
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To midwifery staff: as above, and in addition, 2 annual mandatory midwifery study days where the programme is altered depending on action plans resulting from RCA's. Also through feedback from community midwifery and unit meetings and through Supervision annual review

Beds / Activity:

Number of beds / rooms:	
Labour Ward	9 delivery rooms 3 induction rooms 1 pool room
Triage	None
Obs / HDU on labour ward	None – but recovery area can act as HDU if needed

Antenatal & postnatal		28 plus one bereavement room with double bed
Stand-alone birth centre		None
On-site birth centre		Singleton Unit – 6 beds + 2 pool
Gynae ward		11 beds (Kennington)
Number of staffed labour ward only theatres		(insert hours)
Weekdays	1	24
Out of hours	1	24