Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Royal College of Obstetricians & Gynaecologists
Review of Maternity Services provided by Doncaster & Bassetlaw Teaching Hospitals NHS FT

EXECUTIVE SUMMARY

The RCOG was commissioned to undertake an external review to investigate the care provided by the Maternity services of Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

The Executive Team contacted the RCOG in June 2016 to commission the review following a number of serious clinical incidents which were reviewed through the Trust's clinical governance process and gave rise to concerns around the obstetric service.

Subsequently, a concern was raised by a member of the midwifery staff in September 2016 during a Serious Investigation process. This concern was swiftly followed by further concerns raised by colleagues. In view of this, the terms of reference was amended to include *"review the undermining behaviours between all staff*."

Additionally, the Executive Team felt that there was a lack of integration of the maternity services across the two sites despite Doncaster Royal Infirmary and Bassetlaw District General Hospital having merged into one Trust in 2001.

The review took place on 10-11 November 2016. The assessors found many staff enthusiastic, passionate and caring. However, ways in which service improvements could be made were identified.

The two sites function almost independently which does not realise the benefits of being a single Trust. Some staff in clinical management roles require support to deal with difficult problems, and also require development of their leadership skills.

There is a lack of user involvement in service development and there appears to be little commitment to promotion of midwifery led care and normal birth.

Governance processes cannot provide appropriate assurance to the Board. Throughout the structure there is a lack of appropriate leadership. The Chairs of the Maternity Clinical Governance meeting and the Care Group Clinical Governance meeting neither appear to understand their remit, nor take responsibility for it. The assessors felt that safety issues which needed most urgent attention related to availability of consultants, maternity triage (Doncaster Royal Infirmary), K2 electronic documentation and consultant compliance with mandatory training and the incident review process.

Undermining was evident, mainly but not exclusively within midwifery, and this appeared to have a deleterious effect on patient safety. Although the behaviour of some individuals was being managed there was a perception amongst staff that undermining was not being addressed.

The assessors made recommendations relating to the current service model, governance processes, safety and quality (midwifery staffing, Triage, K2 electronic maternity record and promotion of normality); tackling undermining behaviours and leadership. The assessors also recommended that staff should be provided with feedback from this report, so that they are aware that the Trust has listened to, and acted on their concerns.

Although many recommendations were made, the assessors felt confident that many of the issues could be addressed, resulting in an improvement in the safety and quality of care.