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
CONCLUSIONS IN RELATION TO TERMS OF REFERENCE

To review the current service model and to recommend actions to optimize it for the future

- The two sites function almost independently and this presents risks to patients and to the Trust. There are benefits of scale which could be realised if they worked as a single unit and were encouraged to develop a future strategy for their patients and service. The current service model is very medically oriented and more emphasis on midwifery led care may be timely to ensure a service which is modern and responsive to women and staff.
- The process and decision making for closing the maternity unit needs reviewing to ensure that the final decision rests with a senior midwifery manager rather than a Supervisor of Midwives. The process needs to be described within an Operational Policy and disseminated to all relevant staff including Band 7 Midwives, Matrons and Supervisors of Midwives.
- Several consultants do not have an agreed job plan leading to confusion about responsibility and areas of care.
- There is a lack of user involvement in service development.
- There appears to be little commitment to promotion of midwifery led care and normal birth.

Within the context of this review it is not possible to consider or propose other possible service models for the future.

To look at clinical governance processes across the obstetric department.

- Governance processes are weak and cannot provide appropriate assurance to the Board. Throughout the structure there is a lack of appropriate leadership. The Chairs neither appear to understand their remit, nor take responsibility for it.
- The assessors had concerns in relation to:
    - the risk register which did not include mitigation, actions or progress;
    - actions from Serious Incident Investigation reports which did not have owners or target completion dates;
    - lack of compliance with mandatory training;
    - out of date guidelines.

To advise on the safety and quality of maternity services across the two sites.

- The assessors felt that safety issues which needed most urgent attention related to availability of consultants; maternity triage (DRI); K2 electronic documentation; consultant compliance with mandatory training; and the incident review process.
- In relation to quality of care, there is a need to promote normality, midwifery led care, birth experience and user involvement in service development.

To review the undermining behaviours between all staff.

- Undermining was evident, and this appeared to have a deleterious effect on patient safety. There was also a perception amongst staff that this was not being addressed.

To make recommendations to the Trust based on the Review Team's findings and other issues that arise during the review visit.

See below.

RECOMMENDATIONS

Recommendations where immediate action is required

1 The conduct of consultants who are reluctant to attend when contacted must be addressed by the Care Group Director, supported by Human Resources. Such behaviour is not acceptable and contravenes GMC guidance (Good Medical Practice 2013).

2 A baton bleep system for the consultant on-call must be introduced to ensure that consultants are contactable when on duty in the hospital.

3 Designated individuals and a process for reviewing incidents reported within the maternity service is urgently needed. (The reconfiguration of the Trust risk management team and Patient Safety Midwife post appears to have left a gap within the maternity service).

Further recommendations

Current service model

4 The escalation and closure policy should be reviewed. The decision to close a unit to admissions must rest with a senior midwifery manager and consultant. The process needs to be described within an Operational Policy and disseminated to all relevant staff including Band 7 Midwives, Matrons and Supervisors of Midwives.

Midwifery

5 Develop planned rotations of midwifery staff between the two sites. Staff should be given time to familiarise themselves with both sites and should be given support by their named Supervisor of Midwives to address their learning needs. Shifts on an alternative site should be planned as far as possible and moving staff 'on the day' or within shift should be minimised and the frequency with which this occurs monitored.

6 Matrons or senior midwives should rotate between, or work across both sites to provide positive role models, maintain their visibility and know their workforce on both sites.

7 Specialist midwifery posts such as a Diabetic Midwife, Safeguarding Midwife and Midwives for vulnerable women and Home Birth should be developed cross site and provide support and expert knowledge to both midwives and women.

8 Consideration should be given to reconfiguring community midwifery shift systems or to having a community midwife present on the unit rather than on-call. This will provide the community midwives a more predictable duty roster, and enable women to be given realistic expectations as to whether home birth can be supported.

Medical

9 Consultants in clinical leadership roles, e.g. Labour Ward Lead should have relevant clinical sessions on both sites.

10 Use the forthcoming retirements as an opportunity to reconfigure consultant posts, introducing new posts with sessions on each site (which may be special interest sessions).

11 Consider redeveloping existing and/or developing new consultant posts to alleviate gaps in the junior doctor rota with portions of their job plan providing resident consultant working on delivery suite (see Providing Quality Care for Women – Obstetrics and Gynaecology Workforce RCOG 2016).

12 All consultants must have an agreed signed current job plan. The Care Group Director requires managerial support to facilitate this.

Governance processes

13 The Trust Clinical Governance & Quality Committee must ensure that it gains appropriate assurance from the Care Group Clinical Governance Group, rather than relying on exception reporting. The Care Group Clinical Governance Group must ensure that it is provided appropriate assurance by the Maternity Clinical Governance Group, which in turn should hold its subgroups to account.

14 The Care Group Governance Lead was initially appointed for six months in April 2016. It is therefore the appropriate time to consider whether their tenure should be extended, or whether the role should be re-advertised to give other consultants a development opportunity.

15 The Chairs of the Care Group Clinical Governance Group and the Maternity Clinical Governance Group need to have their remit and responsibilities clearly outlined in a 1:1 face to face conversation with a senior member of the Trust Governance team, so that the Chairs understand what is expected of them in this role.

16 The Trust's policies for Serious Incident Investigation and Investigating Incidents, Complaints & Claims need reviewing as they are out of date. The new policies should ensure multidisciplinary input into both the investigation and the feedback of incidents and mortality reviews.

17 Risk reports (including lower level incidents), review of the maternity dashboard, actions from incidents and guidelines due for review should be standing items on the CDS (Labour Ward) Forum and Maternity Clinical Governance Meeting agenda.

18 Consultants who are not up to date with their mandatory training must be identified, contacted and a date for attendance planned within the next month. There should be ongoing monitoring of this by the education team to ensure all staff remain up to date.

19 A number of appraisals should be spot checked and appraisers held to account if these have not been performed with sufficient rigour, e.g. mandatory training not completed.

Safety and quality

Midwifery staffing

20 Midwifery staffing should be reviewed and areas requiring additional staffing identified and a midwifery staffing strategy put in place to address this. Safe staffing levels (in discussion with both midwives and managers) should be agreed across both sites and adhered to as far as possible. There should be a clear escalation pathway when the agreed staffing levels cannot be met.

Triage

21 A review of triage operating procedures and staffing should be undertaken and appropriate safe staffing levels agreed. The woman's pathway through triage should be reviewed and changes put in place to ensure that appropriate escalation and review takes place in a timely manner.

22 There must be clarification relating to the both junior medical staff and consultants' responsibilities in relation to triage.

23 An audit should be undertaken into whether ward rounds occur as scheduled and the length of time women wait for medical review.

24 A consultant should be designated as the lead for triage. This should be a different consultant from the Labour Ward Lead, although the two will need to work closely together.

K2

25 Further work is needed to resolve the residual problems experienced with the K2 electronic maternity records as this poses a significant risk to patient safety, and to the Trust. Joint working between IT and the midwifery team is needed with additional training for both medical and midwifery staff.

26 Provision of administrative support for inputting data into the K2 system would relieve the workload for midwives, and be a more appropriate use of skills.

27 A way in which health care professionals in other Trusts can access a woman's electronic records in an emergency should be developed, e.g. giving the woman a card with essential details and instructions for electronic access.

Promoting normality

28 The appointment of a Consultant Midwife with a remit for normality (across both sites) would give the opportunity to support midwives in delivering a quality service for women and enhance women's choice. The Consultant Midwife's remit could also include the development and implementation of a co-located Midwifery Led Unit. The views of local women must inform this development.

29 Both midwifery and medical staff must receive further training in promoting active birth and normality. This training should be multidisciplinary to facilitate and improve mutual understanding of roles and responsibilities and where possible users of the service should be invited to provide insight into their experiences.

30 Users should be involved in planning service developments. Whilst the MSLC can assist with this, other ways of engaging users should be considered including at parentcraft reunions; or engaging with women who have complained or suffered as a result of clinical incidents. Clinicians should be proactive in seeking a dialogue about the service with women and relevant voluntary organisations, e.g. Bliss, Sands, NCT, etc. Training events could be vehicles for engaging with voluntary groups.

Tackling undermining behaviours

31 Although undermining behaviour of some individuals is being addressed, it is not apparent to staff that action is being taken. Consideration needs to be given as to how staff can be assured that action is being taken, whilst maintaining confidentiality. Possible options would be staff engagement sessions, team meetings or 'meet the managers' sessions. Resources are also available to assist with this.

32 Senior midwifery and medical staff should ensure their attendance at multidisciplinary meetings, where they should act as positive role models by exhibiting collaborative behaviour, and openly challenging any inappropriate behaviour.

33 Multidisciplinary 'skills and drills' including human factors training, joint engagement and communication meetings of staff across the two sites, alternating the sites, may help break down barriers, improve teamwork and reduce undermining. Involvement of external organisations initially may help initiate change.

34 Ask staff for ideas on how to promote teambuilding, and support sensible suggestions, e.g. communal coffee room, Christmas party, staff Pilates sessions after work.

Leadership

35 The Care Group Director requires support to undertake their role which includes managing consultant performance.

36 Those taking on Clinical Leadership roles should be valued and developed through a leadership programme. They should also be held to account for their sphere of responsibility, by the Care Group or Trust Clinical Governance structure.

37 A formal mentorship or coaching arrangement (which may need to be with someone external to the Trust) should be developed for the clinical managers, with a leadership development programme for the matrons and consultants.

38 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. Providing staff with some examples of actions which will be taken in response to the recommendations will facilitate engagement of staff in improving care