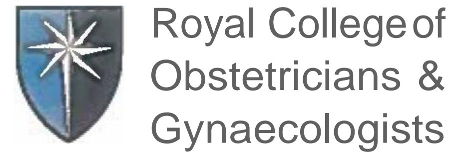

REPORT

Review of Maternity Services provided by Walsall Healthcare NHS Trust

On 4-5 October 2017

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1. EXECUTIVE SUMMARY

The Roy al College of Obstetricians and Gynaecologists (RCOG) was commissioned to undertake an external review to investigate the care provided by the maternity services of Walsall Healthcare NHS Trust.

I n September 201S, a Care Quality Commission (CQC) inspection rated the maternity service in Watsall as 'inadequate'. Following this inspection, a number of changes had been made to the maternity service. However, other changes had either not been made or had been difficult to implement. The CQC revisited the Trust ;n June/July 2017 and highlighted the lack of improvement in some areas from their initial feedback. The issues identified by the CQC related to sta ffing, culture, leadership,
intrapartum fetal monitoring and a medicalised model of care.

tn response to this, external support was requested and the RCOG invited review was commissioned and took place on 4-SOctober 2017.

The assessors found many staff to be enthusiastic, passionate and caring. They had been demoralized by the CQC reports and there had been a period of instability and inertia due to changes in the clinical leadership team. A new Head of Midwifery (HoM) had taken up post, together with a new acting Clinical Director. Both are enthusiastic and improvements have already been made to many aspects of the service, although there is still much to do. Both the acting Clinical Director and the HoM are inexperienced in t heir roles and require support and mentorship, to enable them to deal with the many challenges they will face. Both individuals have the respect of the staff and the assessors felt confident that they would be able to continue to lead the unit along a path to improvement.

Actions have been taken to resolve the staffing problems identified by the CQC, and the midwife: birth ratio has improved significantly. In order to achieve appropriate staffing levels on the hospital delivery suite the midwifery led unit (MLU) has temporarily closed. Although the established number of staff is now better, sickness rates are high resulting in ongoing staffing pressures. The use of a workload acuity tracker has been introduced but many staff do not understand its purpose.

Many of the medical and midwifery staff have trained together in Walsall!, prior to taking up posts there. Whilst this means that there are strong working relationships, it also means that there is an established hierarchy, working in a traditional way, which is difficult to change or challenge. There appear to be tensions between some groups of staff. Staff engagement and team building sessions which had been held had been well received and it is suggested that these should continue. The findings of a report relating to staff experience should also be acted upon to improve the culture within the unit.

Although the Trust had invested in the governance team, a great deal more work is needed to make the governance processes effective. This includes the way in which assurance is gained from ward to Board, the effectiveness of many of the meetings and the risk registers. There is confusion within the maternity unit about the way in which serious incidents should be investigated. Clarity is needed. Other governance work such as audit has not focused on issues highlighted by the CQC as problem areas, and has been ineffective. However, the unit should be praised for the amount of work which has been done updating the large number of guidelines and focusing on two of the clinical issues

highlighted by the CQC -cardiotocograph (CTG) interpretation and the caesarean section rate. By taking ownership of these issues, measurable improvements have been made in these areas.

Consultant job plans require revision, with consideration being given as to what level of out of hours consultant presence and nonresident cover is necessary. Activities within job plans, particularly nonclinical activities such as leadership roles, need to be more clearly designated.

In response to the CQC report a midwifery lead for normality has been appointed, but there still appears to be a lack of passion in some of the midwives to pursue the normality agenda. There was a lack of timely communication to staff about the closure of the MLU, and staff are uncertain about the plans for the MLU in the future. This has been disconcerting for those staff who worked there, and several are planning to seek employment with other Trusts. This would result in the Trust losing midwives who are enthusiastic proponents of normal birth.

Overall the assessors felt that after a difficult period, the maternity unit had turned the corner and was addressing issues. Whilst there are still some substantial challenges to face, the assessors felt confident that the issues could be addressed, resulting in further improvements in the safety and quality of care of women.

2. INTRODUCTION

A review of maternity services was commissioned on behalf of Walsall Healthcare NHS Trust by Mr Amir Khan, Medical Director. This report is based on information provided by the Trust and on interviews undertaken during the visit.

3. NAMES OF REVIEW TEAM MEMBERS

Lead Assessor
Dr XXXXXX
Consultant in Fetal and Maternal Medicine and Deputy Clinical Head of Division
XXXX Hospital, Manchester

Co-Assessor
Dr XXXXXXX
Consultant Obstetrician and Gynaecologist
Divisional Director Women's and Children's Health
XXXXXX Hospital, London

Co-Assessor (Midwifery)
Ms XXXXXXXX
Previous Local Supervising Authority Midwifery Officer and Head of Midwifery (retired)

Co-Assessor (Lay)
Ms XXXXXXXX

4. BACKGROUND FOR REVIEW REQUEST

In September 2015, a CQC inspection rated the maternity service in Walsall as 'inadequate'. Following this inspection, a number of changes were made to the maternity service. Actions were put in place to improve the midwife: birth ratio. Since March 2016, the number of births has been capped at 4200, with women from six GP practices being sign posted towards care in a neighboring Trust (Wolverhampton). Following the 2015 CQC report, the Head of Midwifery (HoM) resigned and it was over 1 year before a new HoM was recruited. Mentorship and coaching was put in place for the clinical director (CD), who has unfortunately had a prolonged period of sick leave, The governance team was supported and restructured with each division allocated a divisional governance advisor, who leads a team of five. The divisional governance advisor is managed by, and accountable to the Trust governance lead rather than the divisional clinical lead. Other changes, described below, were either not made or were difficult to implement.

On 26 June 2017, there was an announced CQC vi sit, with a further unannounced visit on 5 July 2017. The CQC identified continuing problems in relation to midwifery staffing and its impact on the care of women, readmission rates, intrapartum fetal monitoring, a medicalised model of care, leadership, culture and behaviours. The CQC report suggested that the culture and behaviours within the unit posed an obstruction to change, were oppressive, and at times jeopardised governance processes. The fl nal report from this visit was not available at the time of writing.

The Medical Director commissioned the RCOG to review and identify issues facing the service, in addition to supporting the maternity service in identifying the actions needed to deliver sustainable change.

5. TERMS OF REFERENCE

The Terms of Reference were agreed in advance with the Trust:

1. Identify the organisational issues facing the service, with particular focus on medical and midwifery staffing to ensure safe provision of maternity services.
2. Identify areas of clinical practice which are not based on current best practice or national standards, and advise of app roaches to enable change to be implemented.
3. Review intervention rates and suggest ways to reduce inappropriate interventions; in line with the normality agenda.
4. Review the clinical governance arrangements that are in place to ensure a safe and effective maternity service.
5. Review the culture, leadership capability and behaviors within the maternity unit conducive to effective team working.

6. Identify barriers to, and facilitators of sustainable improvement.
7. Provide recommendations, where appropriate, with the aim of improving care for women and their babies.

6. CONTEXT

Population served

Walsall Healthcare NHS Trust serves a population of approximately 260 000 people and is the main secondary care provider for the Walsall Clinical Commissioning Group (CCG). The area is within the most socially deprived quintile nationally and 47% of mothers giving birth in Walsall live in areas of high deprivation. The number of young mothers is higher than the national average, and the number of women of Asian or British Asian ethnicity is almost twice that of the national average.[1]

Management and **governance structure**

The Trust has three clinical divisions and one nonclinical division, with maternity services included within the Women's, Children's and Clinical Support Services Division (WCCSS). The Trust management structure changed recently to promote clinical leadership of the divisions. The divisional director for WCCSS has managerial, governance and financial responsibility for the Division. The Divisional Director of midwifery, gynaecology and sexual health (HoM) is supported by two matrons. The CD for obstetrics and gynaecology is currently on long-term sick leave and the deputy CD has taken over this leadership role, in an acting capacity, i.e. the acting CD.

Each division has a divisional clinical governance advisor who is accountable to the Trust governance lead, rather than the WCCSS divisional clinical lead. The divisional clinical governance advisor leads a team of five people, which includes a quality and governance manager for maternity and gynaecology. One of the consultant obstetricians also has a designated role as obstetric governance lead.

Activity

In 2015-16 there were approximately 5000 births at Walsall Manor Hospital. The birth rate had increased following the difficulties experienced by Mid Staffordshire Hospital (a neighbouring Trust), though there had not been a concomitant increase in staffing, capacity or resources.

Following the adverse CQC report, a decision was made in conjunction with the CCG to reduce the number of births by directing women from a certain geographical area (six GP practices) towards New Cross Hospital, Wolverhampton. This aimed to reduce the number of births to 4200 and improve the midwife: birth ratio. In the current financial year, the number of births projected to occur is 3700.

Services

There is a consultant-led unit (CLU) on the Walsall Manor site and a standalone midwifery-led unit (MLU) less than 1 mile away in the centre of Walsall town (10-minute transfer time). Less than 200 women per year deliver in the standalone MLU. Ongoing difficulties achieving recommended staffing levels within the maternity unit were identified when the CQC revisited the unit in 2017. To ensure

appropriate staffing levels on the CLU at Walsall Manor Hospital a decision was made in July 2017 to temporarily close the standalone MLU and to transfer the staff from the MLU to the CLU.

There is one purpose built obstetric operating theatre and one of the rooms on the delivery suite can be used as a second obstetric theatre if necessary. This room on the delivery suite is s not a purpose built theatre. The facilities are cramped and the neonatal Resuscitaire® is within the theatre. This means that there is a large team of staff standing in theatre during the woman's surgery, which increases the risk of maternal infection. A plan (phase 1) has been agreed to build a second theatre and a new neonatal unit. Subsequently, there would be a further plan (phase 2), which is yet to be agreed, to build an onsite purpose built MLU.

There are currently 142.5 hours of consultant presence on delivery suite. In August, the actual (worked) midwife: birth ratio was 1:29.

Walsall Manor maternity unit has seen the introduction of several specialist midwifery roles for risk, practice development, diabetes, fetal medicine, vaginal birth after previous caesarean section ([VBAC] (recruitment in process) and vulnerable women, which includes drug and alcohol abuse. There are also two roles based within the Trust safeguarding team (teenage pregnancy and safeguarding). There is no baby feeding midwife and no commitment to becoming a *Baby Friendly Hospital* at the present time. However, there is a baby feeding advisor in public health, but this is a non-clinical role and the post-holder is not directly involved in the care of women.

There is a three-bed obstetric triage unit located adjacent to the delivery suite where women with urgent problems can be assessed. There is a separate obstetric assessment unit for women who require more intensive antenatal monitoring where scheduled appointments are booked.

There is a level 2 neonatal unit on the Walsall Manor Hospital site that takes babies above 28 weeks of gestation. New Cross Hospital in Wolverhampton is the nearest level 3 neonatal unit. Tertiary care is provided by Birmingham Women's Hospital. A four-bed transitional care unit has recently been opened on one of the inpatient wards.

Outcomes

In 2015, the stillbirth, neonatal and extended perinatal mortality rates were up to 10% lower than comparable Trusts when stabilised and adjusted for factors known to influence mortality rates.[1]

Examination of the maternity dashboard (August 2017) shows that the caesarean section rate is 28% (emergency lower segment caesarean section [LSCS], 17%; elective LSCS 11%) compared with a national mean of 21.3%.[2] The induction of labour rate is 36% compared with a national mean of 30 .2%.[2] In the last 3 months, the LSCS has been below 30%, where previously it had frequently been above 30%. High rates of intervention and a medicalised model of care were highlighted in the CQC report 2015.

Education

The General Medical Council national training survey 2017 for obstetrics and gynaecology in Walsall had a 'green flag' for regional teaching and a 'pink flag' for clinical supervision and out of hour s' clinical

Supervision. A 'green flag' is a survey result that is significantly better than the average score. Meanwhile, a 'pink flag' is a survey result that is negative, but shares a confidence interval with the national average.

7. DESCRIPTION OF REVIEW PROCESS

The assessors requested specific information and data from the Trust prior to the review. Provision of the documentation requested was not timely, with some documents not arriving until the day before or indeed the day of the review. This did not allow for a timely or full review of the documentation prior to the visit.

On 4-5 October 2017 the assessors visited the Trust (please see Appendix I for timetable). The assessors toured the maternity unit and interviews were conducted with members of staff, representatives from the CCG and the deputy chair of the Maternity Voices Partnership (MVP). The lay assessor also spoke to a number of users of the maternity service in the antenatal clinic.

8. DOCUMENTATION REQUESTED

The following documentation was requested prior to the review:

- managerial structure of Trust
- managerial structure of maternity department
- governance structure of Trust
- maternity services risk management strategy
- maternity complaints summary
- maternity dashboard (last 2 years)
- risk report and summary of incidents (last 2 years)
- list of serious incidents in maternity
- maternity risk register
- divisional risk register
- minutes of maternity clinical governance meetings (last 3 months)
- divisional minutes of safety huddle (last 4 months)
- reports from the divisional quality board (last 9 reports)
- minutes of Trust clinical governance meetings (last 3 months)
- minutes of delivery suite forum (last 3 months)
- minutes of perinatal mortality (last 3 months)
- MBRRACE report (Trust specific)
- report from the work of Sheena Byrom
- audit programme
- audit presentations (last 3 reviewed)
- readmission rates and reasons for readmission
- training needs analysis (all staff)
- training compliance (consultants and junior doctors)
- serious incident investigation reports (last 3 reports for maternity incidents) - relevant case notes were reviewed during the visit
- friends and family test for maternity

- minutes of Maternity Service Liaison Committee (MSLC) and MVP meetings
- MVP terms of reference
- patient experience report for Trust quality executive
- medical job planning policy
- departmental consultant timetable and job plans
- minutes of consultant meetings (last 6 months)
- midwifery staffing audit and report, including acuity tool output (Birthrate Plus report)
- sickness report
- employer-led model of supervision
- guidelines:
    - *Management of Complaints*
    - *Management of Serious Incidents and/or Incident Reporting and Review*
    - *Care of Women in Labour (including MLU)*
    - *Fetal Monitoring in Labour*
    - *Escalation Policy for Maternity*
    - *Suturing*
    - *Use of Translators*

9. GENERAL FINDINGS

During the review, the assessors found that staff were open, honest and forthright in the views and opinions they expressed. Many staff exhibited great loyalty to the Trust and are passionate about the care they provide for women. However, some staff felt that they had been let down by the Trust, that communication is poor and that problems within the unit are not always dealt with in the most appropriate way.

The majority of staff acknowledged that the 201S CQC report had reflected a service with many problems, but felt that they had been harshly criticised at a time when they were working extremely hard. Staff also told the assessors that they felt they had borne the brunt of the criticism, despite many of the problems out with their control, thus leaving staff feeling demoralised.

Some staff described difficult working relationships, particularly between the inpatient wards and the delivery suite; the community and MLU midwives, and the core delivery suite staff; and the clinical team leaders and those with specialist midwifery or managerial roles. There was also evidence of previous interpersonal issues with some of the senior clinicians. However, several staff noted that things are now improving and that the maternity unit is in a better position than it has previously been.

There was evidence of improvement in many of the aspects of care identified as deficient by the CQC, including a reduction in LSCS rates following the introduction of daily reviews and the appointment of a midwife for 'normality'. However, there were also areas where the assessors felt that care and governance processes could be improved and these are discussed in detail below. Although many points are raised, the assessors feel confident that the issues can be addressed, resulting in an improvement in the safety and quality of care of women.

10. FINDINGS AND CRITICAL APPRAISAL OF EVIDENCE

10.1 Leadership

Trust leadership

The Chief Executive and Medical Director appear to have a full understanding of the issues and know the senior members of the team well. They are able to describe the problems in detail, in a meaningful way, and to reflect on the progress made so far. Despite the difficult financial climate, the Trust has invested in maternity services. The management structure within the Trust has been changed to a clinical model, with each division led by a clinician rather than a generic manager.

Midwifery leadership

Shortly after the 2015 CQC visit, the HoM resigned from the Trust. More than 1 year passed before a new HoM was recruited. This was destabilising for the midwifery team. When the new HoM took up their post in January 2017, there remained significant gaps in the senior midwifery team as matron posts did not become active until August 2017. There is no deputy HoM. As a result, the role of the HoM was initially very operational, leaving no time to develop leadership capacity. The new appointee had not previously held a HoM post and although they were initially allocated a mentor, this has now ceased for unknown reasons.

The senior midwifery team is very new, and requires support and development to enable management and cultural change to occur. It is essential that this team works closely and cohesively with clear aims and objectives. It is understood that support is being provided by the King's Fund and the Royal College of Midwives.

The assessors believed that mentorship from an experienced HoM would also be beneficial to the service, as well as the Trust as a whole. Additionally, the appointment of a deputy HoM would provide operational support, enabling the HoM to focus on service development and strategy. There is a good HoM network with regular meetings held. However, due to time constraints, the HoM finds it difficult to attend these meetings; a deputy HoM would facilitate attendance.

Staff are very positive about the new HoM and noted that they are doing a very good job. Staff recognise that the HoM has been working for several months with many of the senior midwifery posts unfilled and staff on long-term sick leave. Staff appreciate the management style of the HoM noting "the HoM gives people space to make decisions and breathe", adding that they are more visible in the clinical settings. Staff are also positive about an open meeting that has been organised by thematrons, which enables staff to meet with the divisional and executive management teams. Staff said that they would appreciate more of such events.

Several members of staff feel that midwifery team leadership, especially on the delivery suite , requires development with a more positive focus. They felt that not all of the team leaders provide good leadership, marginalising rather than supporting some members of the team, particularly the community midwives or midwives who have come from the MLU to work on the hospital delivery suite. It was also apparent that some staff (midwifery and medical) perceive some Band 7 midwifery

team leaders as unsupportive. They noted "you know what sort of a shift you're going to have, when you find out who is in charge".

Medical leadership

In recent months, a deputy CD has been appointed who has taken on the role of acting CD in the CDs absence. The acting CD has limited management experience, but acknowledges this and is keen to access support in this new management role. While there is difficulty in ring-fencing clinical time, the acting CD has been supported by the Trust and has reduced their own clinical workload by two sessions per week. The acting CD also felt that the Trust had been supportive of various initiatives within obstetrics observing "if it's part of an improvement plan then it is given the green light". One area where the acting CD would welcome more support is human resources, which is quoted to be "very thinly spread".

The acting CD has a good relationship with colleagues, but is aware that some find change difficult. The acting CD appears keen to rise to the challenge and explained "my job is to demonstrate that these changes are the best for the department". They feel that with support, it will be possible to engage most colleagues, but has concerns that those who have become disaffected may be more difficult to manage going forward. The acting CD appears to have the support of midwifery, medical and managerial staff, who describe the acting CD as "fantastic, approachable and fair".

There appear to be good working relationships between the Divisional lead, HoM and acting CO. The acting CD valued the support of the Medical Director, describing them as "a good advisor and approachable".

Within the team, the acting CD has plans to ensure that each of the consultants has a leadership role for a particular aspect of the service. These will be divided more equally between the team than at present and time will be allocated within job plans for attendance at the relevant meetings. Currently some consultants do not have SPA time specifically designated for their leadership role, and when it is, it may not coincide with the times that relevant meetings are held. This means that some consultants are inconsistent in attending, and others are unable to attend relevant meetings. Poor attendance at meetings by obstetricians was cited as a reason for the lack and ineffectiveness of change - "their [obstetricians) attendance at meetings is a problem, we can't make decisions".

Some consultants who hold leadership roles for a particular aspect of the service did not appear to have a clear understanding of their role or the issues impacting that aspect of the service. For example, one consultant described their role as dealing with the "day-to-day concerns on labor ward". The consultant did not have a clear understanding of why the MLU had temporarily closed, asserting that it was due to transfer times to the hospital delivery suite. The consultant was also unable to say what the rate of transfer of women in labour from the MLU to the hospital delivery suite was.

There is a leadership development programme within the Trust, but this is only aimed at midwives above Band 7 and CDs. There is no leadership development programme for new consultants or aspiring clinical leaders. The Trust may wish to consider a development programme for aspiring clinical directors, or for newly appointed consultants.

10.2 Staffing

Medical staffing

The majority of consultants have trained within the West Midlands, many having worked in Walsall during their postgraduate training. There are 16 consultants who work at Walsall Manor Hospital, four of whom are locums.

All consultants undertake both obstetrics and gynaecology. However, the proportion varies depending on the special interests of each consultant. Some consultants work less than full time (8 programmed activities {PAs]), and one is the Director of Postgraduate Medical Education.

There is no strong evidence and no clear guidance on the levels of medical staffing for the obstetrics and gynaecology units. At present, in Walsall Manor Hospital, 142.5 hours of consultant presence is provided by 16 consultants, and there are two consultants on duty overnight (one resident and one nonresident). Times when consultants are on call from home, rather than rostered to be present in the unit, are between 19:30-20:30 on weekday evenings, and during the afternoons and evenings at weekends. At all other times there is resident consultant presence. Each night, in addition to the resident consultant, there is a second consultant on call from home. There is also a tier 1 doctor (foundation year, GP specialty trainee, or obstetrics and gynaecology STI-2) and a tier 2 doctor (obstetrics and gynaecology trainee ST3-7) on duty within the hospital. Three consultants work a hybrid rota, with some resident night shifts and some nonresident on call. Five consultants only do nonresident on call.

The level of medical staffing for a unit of this size seems generous. Consideration should be given as to whether 142.5 hours of consultant presence is deemed necessary. While at present it would feel inappropriate to reduce this in a unit where safety concerns have been expressed, consideration could be given as to whether it is necessary to have a second consultant on call from home, given the high level of resident consultant presence. This could also be provided in a different way, for example, by remunerating consultants for each time they are called in. If a decision to maintain consultant presence overnight is made, then a consultant ward round in the early hours of the morning should be introduced to ensure that the consultant is aware of, and proactively managing the care of women on the delivery suite (as they would during day-time hours).

At present, four of the consultants are locums. The clinical management team of the Trust feel that forthcoming substantive appointments will stabilize the workforce and enable development of certain aspects of the service.

All the consultant job plans require review using the Trust job planning guidance. The allocation of supporting professional activities (SPAs), i.e. nonclinical time, within the job plans appears generous, with all consultants allocated at least two SPAs. In many cases, the SPA time is not designated to specific activities, although most consultants have a leadership role within the care group. All consultants have been asked to allocate time for governance activities, but this is not specified within the SPA time. No time is allocated within job plans for patient administration (a direct clinical care {DCC) activity) and the assessors learned that this is done within SPA time. It would be appropriate to redesignate some of the SPA time as DCC time for clinical administration. It should be clarified within

job plans how much of the current SPA time is allocated for the various leadership roles and to make these 'outcome-based SPAs'. SPA time, which is not allocated for specific roles or activities, could then be either converted to clinical time, removed from job plans or be used to support other activities, such as governance.

An electronic appraisal system is used, but the CD is unable to see the appraisals of the individuals in their team. The assessors were advised that individual appraisers may feedback to the CD. However, this does not seem appropriate. The appraisal discussion should be confidential and, therefore, it is not appropriate for informal feedback to be provided by appraisers following some appraisals. The CD should be **aware** of, and agree to the personal development plan, as this needs to be congruent with the objectives of the department. There should be a formal mechanism in place for each consultant to **agree** their personal development plan with the CD after appraisal.

Antenatal clinics are frequently not reduced when consultants are on leave and the allocation of junior doctors to that particular clinic is not increased. This can result in junior doctors being overwhelmed, resulting in women having longer waiting times and possibly a less t thorough assessment. The assessors recommend that either the number of women attending clinic should be reduced, or formal arrangements for ensuring adequate medical cover are made.

Midwifery staffing

Midwifery staffing has changed significantly since the 2015 CQC visit. The birth rate was reduced to 4200 per year and has subsequently fallen further. For 2017 the anticipated birth rate was 3700, leading to an anticipated midwife: birth ratio of 1:25. However, at the time of the review, there was a vacancy factor of 4.6% (seven vacancies). Therefore, taking into account sickness and vacancies, the midwife: birth ratio is 1:27. Sickness rates are high, particularly among community midwives and delivery suite staff (12.1% and 11.5%, respectively). Midwifery staffing levels are being monitored monthly and are displayed on the maternity dashboard. This appears as a worked ratio, i.e. excluding sickness, annual leave and maternity leave. A standard amount is calculated into the Birth rate Plus" ratio. However, the sickness and maternity leave rate is high at Walsall.

Uncertainty around the future of the MLU has resulted in some midwives seeking employment in other units with MLUs. The assessors also learned that some midwives had been declined their request to reduce their working hours and subsequently had left the Trust and moved to another unit. A more flexible approach to less than full-time working may improve retention. In order to address the high vacancy and turnover rate, recruitment is underway for 13 whole-time equivalent staff.

Staffing on the delivery suite appeared to be a particular concern. An acuity tool was being used, but there seemed to be considerable confusion around the use of the too t Staff frequently indicated that there should be 11 midwives on the delivery suit e and this appeared to be the number that had been customary. The acuity tool bases staffing on the acuity of women on the delivery suite at the time and is reviewed every 4 hours. Therefore, required numbers of staff varies according to the workload. Staff either did not understand or did not want to accept the acuity tool. The tool is to be used in a meaningful way, more work needs to be done to embed its use. The midwifery managers should utilise it to redeploy staff within the unit when the delivery suite is either particularly busy or conversely, quiet.

Recently, there has been a major change within the midwifery profession and supervisors of midwives have been replaced by a new model that is under development. Supervisors of midwives no longer exist. However, each Trust is responsible for developing their own model or utilising the national A-Equip model, which supports the appointment of trained professional midwifery advisors. This change occurred in April 2017. At present, this is still in development in Walsall. The HoM informed the assessors that there are plans at this time to train five midwives for this role. It is of note that no previous supervisors wish to take on this role.

10.3 The normality agenda

The CQC 2015 described a medicalised model of care with high intervention rates. Since this report, a midwifery lead for normality has been appointed. There are active birth beds and sufficient equipment, but as stated by some interviewees, the staff "need to get into the mindset".

One of the positive aspects of the temporary closure of the MLU is that the community and MLU midwives are working together on the delivery suite. Staff explained they felt this meant "more women can have aspects of 'normal' care, rather than just low-risk women". However, some of the midwives working in the MLU expressed feelings of being undervalued and subsequently seeking employment in alternative MLUs. If the Trust wishes to retain these individuals, it is essential that they feel valued and take a leading role in the development of midwifery-led care within the main unit. The Trust should also provide reassurance that the closure of the standalone MLU is only temporary. The skills of these midwives are essential in refocusing the normalisation of care within the unit.

During the interviews the assessors were surprised that some of the senior midwifery team did not express a desire to reopen the MLU, and appeared to have accepted its closure. The assessors were not provided with an action plan or criteria to meet for its reopening. Some staff suggested that alternative options should be considered for the MLU if it is not opened fully as a birth centre. In addition, there was an acceptance that the closure of the MLU may be permanent. However, the Chief Executive appeared clear that the closure was only temporary. It is important that this position is clarified and clearly communicated to all members of staff.

The assessors were informed that new pathways are being implemented through the antenatal clinic to identify women for midwifery-led care who are low risk at booking; rather than all women being allocated to a consultant. It is important that this is embraced by all clinicians, both obstetricians and midwives. There should also be a facility to refer women to a consultant obstetrician for an opinion with the option to either continue with midwifery-led care or transfer to obstetric care. This is in line with best practice.

Medical staff commented that it is not always easy to determine which of the women on delivery suite only require care from a midwife. The current way of working to identify women receiving midwifery-led care easily, is that 'MLC' is noted at the side of a woman's name on the board. Other methods may be more efficient however. For example, writing the names of these women in green. There was discussion about two of the rooms on the delivery suite being designated for low-risk women. This did

not seem to have been put into effect, and yet, a room with a pool was kept available in case anyone wanted to use it.

Despite the closure of the MLU and more low-risk women birthing in the hospital, fewer than 10 women per month had used the pool in July and August.

In response to the 2015 CQC report, the Divisional and Trust team have supported the midwifery management in promoting normalisation. In order to facilitate this, active birth beds have been purchased. This is a positive step, but training in their use to promote normal birth needs to occur to prevent the beds being used in a standard manner. The attitude of the whole team (medical and midwifery) needs to improve. There appears to have been limited user involvement in the strategy for promoting normality and greater involvement of women would be beneficial.

The assessors were under the impression that the unit had increased focus on the promotion of normality recently, but that the normality agenda had not yet been fully embedded. However, with the appointment of a normality lead and the engagement of all staff (midwifery and medical), it is expected that this will become more established, enabling the normalisation of births for women in Walsall within the main unit as well as within the MLU.

A recent report commissioned from an external midwifery expert indicated reluctance by some midwives to change the status quo, but most significantly, it illustrated a reluctance to embrace a normalised birthing model. The report quotes "there is a reluctance to challenge the status quo, even when presented with evidence and stimuli for change, and generally, teams like to continue with 'custom and practice"'. As a result of this work, an action plan has been produced and is being taken forward.

In addition, a transformation document relating to the national Better Births Maternity Transformation Project[3] has been produced in conjunction with the Local Maternity System. The document outlines 32 actions, some of which have been RAG rated, with others noted as commenced or ongoing. It is important that this document continues to be reviewed and updated with an assurance that actions are completed.

10.4 Culture

The previous HoM had worked in Walsall for more than 30 years. In addition, many of the midwifery and consultant staff have trained and worked for many years together. This appears to have created an insular environment with a lack of challenge and encouraging groupthink. The assessors learned that any staff who thought differently were marginalised. After the 2015 CQC report there was a perception of a process deliberately destabilising the 'old regime' which caused upset. Some individuals felt a level of injustice from the organization, which has been difficult to put aside. Tension between some of the clinicians and managerial staff was evident to the assessors with each being critical of the behavior of the other. More recently, there have been various workshops to encourage reflection, as well as engagement sessions to promote communication.

Many of the consultants had completed some of their specialist training at Walsall and people who had previously been their trainers were now their consultant colleagues. The hospital is relatively small and while this has the strength of a closely knit team, it makes it more difficult for junior colleagues to challenge more senior colleagues. There appeared to have been some improvement and staff evaluated it as being good 70% of the time and bad 30% of the time, adding that it used to be the other way round (bad 70%; good 30%). Some staff spoke of a gradual change in the culture, but most explained that this change was slow and "not a seismic shift". Others noted that it was "pockets of individuals, rather than an overall culture''. Staff also explained that the culture shifts depending on who is on duty.

Several staff described poor behaviours of some consultants and senior midwives. They felt midwives and consultants were complicit in this poor behaviour. For consultants, this related to behaviours in meetings, such as sniggering when other consultants were speaking, or being bullish and rude to other consultants, including talking over them.

Staff also noted that some of the midwifery team leaders undermined the community midwives and midwives who came from the MLU to work on the delivery suite. An example given of this was that they ridiculed midwives for not being able to manage women with epidurals, rather than valuing their skills in promoting normality. Some staff commented that the expectations of some senior midwives are different. They also explained that comments they make are often undermined or they are unsupportive of more junior midwives, making statements such as "in our day we'd have just got on with it". Staff were asked about the effect of these poor interactions on the care of women on delivery suite, responding "the women wouldn't see it; the worry is that junior midwives don't feel able to challenge, express concerns or question". Some midwives spoke of a strong dictatorial culture in which job satisfaction and willingness to ask for assistance is dependent on which team leaders are on duty. Some described the culture as being "done to" and being criticised. One interviewee stated "they think they're being funny as they demean others". There have been some new appointments to these roles, which seem to have had a positive effect on morale. Staff commented on the fact that when these new appointees are on duty they feel supported.

The assessors learned that these behaviours had occurred in the past and that the undermining behaviour remained a problem. Interviewees who were critical of the way in which some individuals behave were extremely clear that these individuals are excellent clinicians and never rude to patients. In fact, they were very complimentary about their communication with women.

Some staff felt that these behaviours, and the culture it generated, had not been addressed, describing the individuals as "the untouchables" and immune from any sanctions. Others felt that the long standing working relationships between senior staff meant that it was impossible to change. Managing the poor behaviours had not been taken forward as a formal process. Since it was not obvious that bad behaviours were being tackled, staff were under the impression that nothing was being done to improve them. Midwives stated that they were reluctant to report these concerns due to fear of recrimination.

The above issues were highlighted by the CQC, and the Trust has tried to tackle them. Staff described the atmosphere to be very uncomfortable and some staff felt that their contribution over many years

Had not been valued, leading them to become disaffected and resentful. The assessors appreciated the honesty of these individuals in expressing the way they felt. Although these were senior clinicians with a wealth of clinical experience, poor behaviours must be addressed and those who exhibit them need to understand the impact it has on others. The best outcome would be a change in behaviours and re-engagement. An appropriate role to enable this change to occur should be considered, for example mentoring or supporting a more junior colleague to take on a more senior clinical role or a leadershiprole for a particular aspect of the service such as governance or shift co-ordinator.

Examples were also given of members of staff, on a personal level, being blocked on social media sites. There was also discussion on about forthcoming recruitment to roles and staff preemptively knowing who will get the job. While this is not directly employment related it destroys t rust and confidence in fellow workers.

Comments were also made about the friction between delivery suite midwives and ward midwives, or midwives in more managerial and developmental roles, explaining "labour ward midwives have an attitude of 'I work on labour ward, therefore, I'm more important than you"'. Midwives other than the core midwives are on rotation. However, there is an upstairs/downstairs attitude between the wards and the delivery suite. In order to ensure the smooth working of the unit, this needs to be addressed, either by the rotation of core staff or the establishment of inclusive team leader meetings.

The CQC inspections highlighted cultural problems within the maternity unit. The staff engagement lead for the Trust had spent time within the maternity unit and this report corroborates the CQC concerns, giving examples of the issues. It should be utilized with staff to enable them to reflect on and discuss the identified issues to assist in the cultUral change.

There are positive team leaders who do support and facilitate midwives, and these individuals should be valued and supported to ensure t heir retention, and the culture and behavioral change needed within the unit.

Midwifery staff spoke of not feeling valued and only finding out about t things via a third part y. An example of this was the closure of the MLU. While management felt they had communicated their reasons for the closure and that it is only a temporary measure to ensurere appropriate staffing on the delivery suite, midwives and doctors were not always aware of the temporary nature of the dosing or the rationale for it. Several midwives informed the team that they found out about the closure via social media on the Trust's Facebook page. In one case, a midwife was informed about the Facebook page via a woman in their care. This has led to insecurity and concerns that as a result of the CQC report when the new unit at Sandwell opens, the Walsall maternity unit will close. While communication in a large organisation is always challenging, it is vital that staff are apprised of the situation before it becomes public knowledge, not only for their information, but also in order to reassure e the women they care for. It was noted that there have recently been open meetings that have been helpful to staff. The maternity management is encouraged to continue and expand these meetings to assist with communicate ion, and subsequently reduce speculation and rumour.

Midwives spoke of the numerous changes that had occurred recently and many welcomed them, noting improvements in the right direction. However, with so many changes occurring at once, staff

are struggling to keep up. Staff were uncertain whether the care they are providing is in accordance with current guidelines. A structured action plan, with appropriate timescales, would enable one change to be embedded before the next change is introduced. Making the plan available to all staff would allow ownership and engagement in the changes, reducing the feeling of being 'imposed upon'.

The HoM has an open door policy, which staff are aware of, but some staff commented that they do not currently feel able to express their views openly to them. It is accepted that it will take time for the HoM to build the trust of the staff and it is hoped that this will be utilised in the future to help take the service forward.

The Trust Improvement Director arranged for a facilitator to run focus groups. Health Education England has also done workshops with staff, and Edgecumbe (a leadership and engagement consultancy company) has also been involved. Some of the senior members of the midwifery staff had also arranged meetings between the management team (including the Chief Executive) and Band 7 midwives. When asked about whether the culture had changed, staff noted that it was more open than previously. The assessors gained the impression that while change is happening, there is still a way to go. However, this is a journey that has started and with a more stable management the structure is progressing.

The consultants who have been in post longest do on call from home, while the younger more newly appointed consultants do more resident night shifts. The assessors specifically asked whether this created a perception of a two tier consultant grade, with those consultants doing nonresident on call being seen as more senior than those doing resident shift s. Consultants and junior doctors had mixed views on this. The instigation of a hybrid rota where some consultants do both resident and nonresident on call appears to have mitigated the perception of a two tier system. The acting CD works a hybrid rota and this is a positive way of dispelling this perception. Resident consultants have leadership roles for particular aspects of the service, which again enables them to be seen as having equal responsibilities and respect, and facilitates their own professional development. Recently, the consultants have been provided with an office, based on delivery suit e. This is seen as a positive move, and allow s for greater contact with the junior doctors and midwives.

Medical and midwifery staff at all levels disclosed that the Trust is not a good place to work at the present time, with some of them looking for alternative employment. There was a lack of enthusiasm from junior staff to make Walsall their career choice. A lack of supportive team working was identified as one of the factors affecting this. There was an acknowledgement by consultants and midwives that they had been working in silos. The issues were expressed to be multifactorial, but staff felt that this was starting to improve. Counter to this, staff feel that there is a good working relationship between midwives and consultants.There seemed to be a divide between managers and clinical staff.However, with the new acting CD and HoM it appears that this may be improving, but there is still suspicion relating to management. This 'usversus them' attitude needs to be addressed in a supportive manner in order for the service to move forward. A recent open forum attended by staff and members of the divisional and executive teams was well received, and the assessors recommend that this should be repeated on a regular basis.

10.5 Governance

A major concern from the 2015 CQC report was in relation to governance within maternity services. Consequently, the governance team had been strengthened following the 2015 CQC report, with a team of five working within WCCSS. The governance team reports to the Trust governance team, rather than within the division. The governance team expressed difficulty in getting clinicians to engage with the governance processes, but noted that there was some improvement in this. They commented that previously there had been a deliberate ignorance to governance and that emails would go ignored. Within the maternity unit, the maternity risk midwife has worked extremely hard to improve relationships with clinicians. The maternity risk midwife has earned the respect of the clinicians and has turned difficult working relationships into productive ones. The consultants are very supportive of the risk midwife, who in turn appreciates the change in attitude of consultants.

The CQC report in 2015 noted low levels of incident reporting, which has now improved. Within the minutes of the maternity risk group there is evidence that the completeness of incident reporting is being ascertained, by checking data from the maternity information system against the number of incident reports e.g. for post-partum haemorrhages, third degree tears. There is therefore confidence that the increase in numbers of incident reported represents better reporting, rather than an increase in the number of incidents occurring.

The assessors were told that once incidents are reported, ward managers review the less serious incidents, the moderately severe incidents undergo 'tabletop' review and the serious incidents have a formal root cause analysis (RCA) investigation. However, it was not clear to the assessors, or to staff, how the decision is made as to whether a 'tabletop' review is performed or a formal investigation . The guidelines *'Incident Reporting, Learning and Management Policy'* lacked clarity on this point.

There were differing views and a lack of clarity as to who should attend the tabletop review. Some staff disclosed that they felt as though they were on trial when they were required to attend. Originally, tabletop meetings had required all staff involved to attend and this was seen as a blame process to some of those involved. Subsequently, clinicians were no longer invited and this again led to a sense of blame. The governance team has now made it optional for clinicians to attend. Those involved may or may not be present at this meeting.

The process of formal investigation of serious incidents was not clear, with staff describing differing processesIt appears that the governance team or risk midwife completes the investigation and writes a report, which then goes to a panel meeting. The panel consists of a chair (independent of the division), an obstetrician (independent of the incident) and possibly a midwife. At the meeting, which usually fasts about 2 hours, the report is discussed. The report is then returned to the risk midwife for revision, if required. Multi-disciplinary input only occurs during the panel meeting, and at that time with limited review of the contents of the clinical notes or statements from staff. There is the potential for important points to be missed, or inappropriate conclusions drawn.

The governance team revealed to the assessors that , at times, they had felt uncomfortable with the conclusions drawn, as well as with the rigor of some investigations. They felt that consultants

investigating incidents often supported rather than challenged their colleagues. The conclusions of one report had been questioned by the governance team, but not revised.

On completion, reports are sent to five individuals with divisional management roles. Two of the five do not have a clinical background, and the others may not necessarily have the appropriate knowledge of the specialty. The report is then sent to the executive team for sign off. It was not clear whether this is the quality assurance process, and whether queries or requests for clarification were made at this stage, or whether there was a separate quality assurance process. The Divisional Lead was unable to give a clear description of the quality assurance process for the reports, which led the assessors to question how they could be assured of their rigor.

There is still room for development of the serious incident investigation (RCA) process and this should follow the Serious Incident Framework[4]. It would be advisable that there was multi-disciplinary clinician involvement at the investigative stage. It will also enhance the opportunities for earlier escalation of issues and give responsibility to clinicians for ensuring actions are followed up in a more timely fashion. Most importantly, it would assist in ensuring responsibility and ownership of the investigation process, adding quality assurance within their own service. This process would then be facilitated rather than undertaken by the governance team. Consequently, this may assist in reducing the impression of a blame culture. It would, however, require a greater number of clinicians to be trained in the investigation process and RCA techniques. Some training is provided within the Trust, and some clinicians have received training in other ways. Governance processes would be strengthened by the Trust compiling a list of trained investigators, who could then perform investigations. SPA time would need to be designated within the job plans of the investigators for this.

The assessors reviewed the notes of four women where serious incidents had occurred (three maternity and one gynaecology). Review of intrapartum documentation was difficult as this was a computer-based system and the availability of a printed record was not practical. Consideration needs to be given as to how notes of the labour progress could be made available for service users in the event that they request a copy of their notes. One of the incidents included questions from the parents and another addressed questions raised in a complaint. Overall, the assessors felt that the investigations did not address all of the issues. For example, in one case there was disagreement between staff about the classification of a CTG. However, the team reviewing the incident did not give their view as to what was the correct classification and whether the management was appropriate. Other issues which did not appear to have been addressed included: whether there was a guideline for mild-moderate hypertension in pregnancy; indications for a medical review of a patient on the fetal assessment unit; whether an instrumental delivery should have been performed on a woman where there were concerns about fetal wellbeing; and why consultants were not involved in decision making on the delivery suite during normal working hours on a weekday. The assessors therefore questioned the rigour of the investigations and the quality assurance process for the reports. Review of the reports raised concern as to whether the authors or the signatories who signed off the report really understood the meaning of 'root cause'.

All reports reviewed by the assessors discussed the duty of candour and women were provided with a copy of the investigation report at a feedback meeting.

At present, staff within the maternity unit have the view that the governance team is responsible for following up action plans to ensure completion of actions. However, ownership, accountability and responsibility for this should lie within the maternity service and be quality assured by governance.

Although the junior doctors saw their educational supervisors as supportive following an incident, recent changes in midwifery supervision has left some midwives feeling unsupported. It is important to ensure that all staff are supported following an incident and that they are aware of the process and outcome of any incident they have been involved in; for midwives this may be through another system, such as Professional Midwifery Advocates.

The 2015 CQC report also highlighted that staff felt they did not get feedback from incidents. Staff explained that they now get a bulletin with their rota each week and there are daily safety huddles.

The assessors had the opportunity to meet with the Head of Patient Relations, who has seen a reduction in complaints in maternity. On average, the women and children's division receive approximately six complaints a month and the Head of Patient Relations was extremely positive, describing the division as exemplar in handling complaints. An area for improvement, however, is noted to be the following up of action plans and the provision of evidence that action plans have been completed. The patient relations department provides staff with a list of complaints and compliments for their appraisal.

When the assessors reviewed the maternity risk register it did not appear to show what is being done to mitigate risks or what resources need to be in place to reduce the risk. During discussions, the assessors were assured that this information is stored within a spreadsheet, but were not afforded the opportunity to review this. Inconsistencies were identified between the maternity and divisional risk registers. For example, within maternity, midwifery staffing scored 9, but scored 12 on the divisional risk register. The maternity risk register does not accurately reflect the risks; in relation to midwifery staffing, the stated risk is "capacity and demand: High levels of activity within maternity services and resulting failure to comply with nationally recommended midwife to birth ratio" . However, since the capping of births, activity has reduced. The staffing problems are now due to problems with recruitment and high levels of sickness that require different interventions and mitigations than 'capacity and demand'. Some issues that have now been resolved remain on the risk register, for example, midwives acting as scrub practitioners, the need for a second resuscitaire and out of date guidelines. Other risks with high scores are on the maternity risk register, but not the divisional register, for example, lone worker policy and the difficulties community midwives have in being able to respond to safeguarding concerns. The risk register needs to provide the executive team with an accurate reflection of current unresolved risks. The maternity and divisional risk registers should be reviewed to ensure that they concord.

The assessors were concerned that some of the meetings or forums that formed part of the maternity governance structure were not effective.

The delivery suite forum was peony attended with only five people present in April and August; no forums were held in Jun e or July. Large portions of the minutes from the August forum repeat the

minutes from May verbatim. Progress with actions is extremely slow and individuals do not appear to be held accountable for the completion of their actions. For example, the preterm labour guideline was declared as 'in progress' in the minutes reviewed by the assessors from April to August. There was also a delay of several months before the induction of labour and LSCS audits were presented. However, there was excellent engagement from a consultant anaesthetist.

The minutes of the maternity risk management group led to the assessor's opinion of an ineffective group. There were few identified actions from the discussions and it was not clear who was taking any actions forward. No progress was made with the review or implementation of the National Safety Standards for Invasive Procedures (Nat SSIPs).[5] Attendance by members of the group was inconsistent and frequently there was no feedback from other relevant meetings. The chair of the meeting changed repeatedly. Figures from the dashboard were reported, but no discussion or actions stemmed from this. Although items appeared within consecutive minutes, these were repeatedly not discussed, for example, the World Health Organisation checklist, venous thromboembolism (despite this being an item on the risk register) and hand hygiene audits. Issues which had previously been highlighted as areas of concern by the CQC, did not appear to be discussed, for example, decision to delivery interval for category 1 (emergency) LSCS.

The assessors recommend the following for the maternity risk management group: a consistent chair; review of the terms of reference and role description for the chair; and mentorship of the chair from a more senior clinician or member of the governance team to ensure that the group is effective. The Divisional Governance Lead should hold the chair of the maternity risk management group to account by challenging and seeking assurance that issues are being dealt with effectively and in a timely manner.

There appear to be similar problems with the divisional quality team meeting. The June meeting was abandoned due to lack of attendees with many agenda items not discussed. The learning points describe what should happen, rather than how the team will ensure they happen and gain assurance that it does, for example, "specimen labelling: all specimens should be clearly labelled with the patient details and the specimen type"; no actions or assurance measures were listed. The Nat SSIPs guidance was not mentioned and no assurance sought that this had been implemented within the care groups. However, it did feature on the maternity risk group agenda, but was deferred. Feedback from the CQC visit was given, but there were no ensuing actions or assurance that actions were being taken. Minutes were cursory and did not explore the root cause of known problems, such as midwifery staffing levels. There appears to be a lack of effective actions, as well as a lack of accountability for ensuring governance issues are addressed. There is a need for increased challenge from Trust level.

The team in Walsall acknowledged there were many out of date guidelines, but over the last few months, a large amount of work had been done to revise the guidelines, reducing the number requiring revision to six. Therefore, 94% of the guidelines are up to date with work being undertaken on the other six. Previously, many guidelines had been reviewed within a short period of time prior to a Clinical Negligence Scheme for Trusts (CNST) inspection, which meant that many guidelines required review at the same time 3 years later. The governance team and the HoM have done a lot of work writing and ratifying guidelines, sometimes with limited support from other clinicians in the team. The review dates have now been staggered to facilitate their review in a more manageable way.

Demonstrable progress has been made and the team should be praised for their hard work. Unfortunately, evidence in the delivery suite forum minutes presented very slow progress in the review of one guideline (preterm labour), which remained on the agenda for many months. There is also a tendency to copy the practice of other units when developing guidelines, rather than examining the evidence, for example, the timing of the commencement of oxytocin after amniotomy. Some aspects of the guidelines that were reviewed did not reflect NICE guidance or had chosen to disregard NICE guidance, such as recommending recording an average fetal heart rate, rather than recording a single fetal heart rate when performing intermittent auscultation in labour.

10.6 Audits

There is an audit plan with consultants acting as the leads for the various audits. There was no midwifery involvement in the audit plan.

The assessors were provided with copies of three audit presentations: induction of labour; second stage LSCS; and reducing the caesarean section rate. The presentations did not reflect a robust audit process, where standards are set, compliance measured and an action plan developed. Although standards were included in two of the three audits, the assessment of compliance with the standards was not always clear. A large amount of demographic data, which was not of relevance to the standards, was included, together with case studies. Two of the audits had recommendations, but no action plan; the third identified the findings, but did not give clear indication of recommendations or actions for taking the findings forward. The two audits that did include recommendations, recommended that the standards be adhered to, but did not state what changes would be put in place, by whom and when, to encourage better compliance with the standards.

The audits had been completed by junior doctors, but closer direction and supervision by senior staff with more understanding of the audit process may have led to more robust recommendations and actions, and subsequently, meaningful service improvements. There would also have been more educational benefit for the junior doctors if they had more guidance on the audit process.

There was no evidence provided of any audits undertaken or contributed to by midwives. Such audits would help to take the midwifery service forward by identifying good practice as well as practices requiring development. Each of the changes currently being introduced should be audited to ensure their effectiveness, and the midwifery team should be advised to consider evaluating the changes introduced .

An assertion was made that "audits often justify the intervention, rather than looking to change". It was the view of the assessors that the audits were not of a quality to promote change. The audit lead must ensure that a more rigorous approach is taken when audits are performed, so that the audit process leads to meaningful improvements in care.

10.7 Outcomes

The CQCreport hadhighlighted delays in amniotomy for women being induced, suturing, elective LSCS and antibiotic administration to babies, and prolonged decision-to-delivery intervals for emergency (category 1) LSCS. None of these are monitored on the maternity dashboard.

The assessors were not provided with any data relating to delays in amniotomy. An induction of labour audit had been performed, but it did not address this issue, instead focusing on the indications for induction.

No data were provided regarding delays in suturing, elective LSCS or antibiotic administration to babies. The maternity unit did not appear to have used the CQC report to trigger focused pieces of quality improvement work.

Some data on decision-to-delivery interval were included within a 'second stage LSCS audit', but decision-to-delivery interval for all category 1 LSCS does not seem to have been audited or monitored. The Labour Ward Lead should explore whether these data could be extracted from the electronic BadgerNet system.

The CQC report also commented on high postnatal readmission rates. These were reviewed and the Trust recognised that the data they had provided to the CQC were inaccurate. The CQC had been told that the readmission rate was 6.3%, when in fact it was 3.2%. Review of the readmissions concluded that some women could have been managed as outpatients and increased consultant involvement in their care when they presented again was recommended. The rate of readmissions recorded on the maternity dashboard is monitored . In April, May and June, the rate was between 3% and 4%, but rose to 6.8% in July and 5.5% in August. This rise in the rate has not been addressed.

The Trust would be advised to include all these issues in their maternity dashboard and review them on a regular basis with the aim of ensuring good practice in all of these areas. The maternity dashboard should be reviewed to ensure that areas of particular concern are monitored and the dashboard should be discussed in a meaningful way at the relevant meetings, for example, the delivery suite forum and governance meetings.

In line with the normality agenda, and with a view to reducing the LSCS rate, daily reviews of women who have been delivered by LSCS have been instigated. This has successfully reduced the LSCS rate . Between June and August 2017, the LSCS rate was below 30%, whereas in February and March the rate was over 30%. The team should be congratulated on this.

10.8 Training

Compliance with mandatory training within the midwifery workforce is poor, particularly on the inpatient wards where only 76% of staff had completed it. The assessors were informed that the CQC based some of their conclusions on incorrect statistics in relation to training (as had occurred with the readmission rates). While this may or may not be true, it identifies a concern that the Trust was unable to provide the CQC with accurate statistics. It is essential that any statistics provided are quality assured for accuracy and should be easily available on an ongoing basis to allow anyone who uses these statistics timely access to accurate information. It is also of concern that these figures, which provide the divisional leads and board members with assurance, had not been questioned.

CQC expressed concerns regarding the ongoing education and training of staff. In response to this, they have appointed a Practice Development Midwife (PDM). There was previously a lack of competency packages for midwifery skills. Since the appointment of the HoM, they have ensured that there are now competency packages for suturing, cannulation and patient controlled analgesia. At present, approximately 75- 89%of staff have received training and the PDM anticipates that this will reach 95% by the end of the year.

The PDM runs PROMPT and clinical update training each month, and notes that the consultants are very helpful. However, clinical commitments sometimes prevent them from being available for the day. This needs to be addressed and consultant job plans should be adjusted to enable them to contribute to this training. There is a major backlog in the training of staff. In order to facilitate more skills and drills training, it would be helpful to obtain the support of a Band 5 or 6 midwife to assist with the backlog. Thus, allowing the PDM to plan for further enhancements to the basic training. It would also be beneficial to provide some administrative support to maintain records for the midwives, doctors and support staff, ensuring they update in a timely manner. The administrative support could also deliver tasks su ch as room bookings and timings. A senior midwife is an expensive resource to undertake such functions and for which they would not be as well equipped.

As discussed above, many changes are being introduced to the maternity unit at present. This is commendable, but it is important that the relevant training is put in pace to enable staff to change their practice. It does not matter what new innovations are introduced, if appropriate training for staff is not undertaken, the new equipment will be redundant. This is best illustrated with the introduction of cell salvage. The equipment was introduced, but could not be utilised due to the lack of training of staff. A further example is that of the active birth beds that have been introduced. The assessors were informed that *'we have the equipme nt we just need the mindset'*.

Junior doctors described consultants as supportive, noting that they always provide help or advice as need ed. Consultants are generally available during the night shifts and there is good clink al supervision for operating lists, but not always in clinics. Jun i or doctors are released to attend teaching sessions.

10.9 Women's experience

With all of the issues identified with the service, the focus on the women could easily be lost. Women are frequently referred to as patients, which may reflect the culture of the unit (traditional with a lack of focus on normality). Out of respect for the women who use the service, it is important to look at the nomenclature used.

The Trust has a dedicated interpreting service for people whose first language is not English. A VBAC clinic has been established to learn from women's experiences, and to improve their options and choice of delivery for subsequent births. In addition, a miscarriage support group was established in the autumn of 2016 and consideration is being given to setting up a group in relation to fetal abnormalities. The Trust also provides a bereavement service. There is also a neonatal parent support group that meets monthly at a health centre. A breastfeeding support team and postnatal breastfeeding group are available in local Sure Start centres. However, there is no specific breastfeeding coordinator for maternity services despite indication from staff that there should be such a post.

A pregnancy support service is attached to the antenatal clinic, to identify vulnerable women and families in order to offer additional relevant support. All of the women spoken to within the antenatal clinic expressed satisfaction with the service they are receiving. However, one woman expressed disappointment at not being able to give birth on the MLU and staff providing different reasons for its current closure.

The Trust has a patient relations department covering all divisions. The lead for patient relations explained that their team includes patient advice and liaison service staff who provide support for making complaints via the NHS complaints procedure and signposting to independent complaints advocacy, as well as providing wide-ranging information. Leaflets about the patient relations team are available throughout the hospital, including an easy read leaflet. The manager is involved in updating the latest complaints policy and also initiated hand in hand customer care programmes across the Trust. The manager feeds back lessons learned from complaints and attends the Trust-wide patient experience group.

The Trust resurrected its Maternity Services Liaison Committee (MSLC) in the summer of 2016 with invitations to multidisciplinary staff, local relevant support groups and service users. A promotional event arranged for the autumn of 2016 did not appear to happen. By spring 2017, the MSLC had recruited service users to be chair and vice chair, but had struggled to attract women using maternity services. The terms of reference continued to be updated and a proposal was made to change the name of the committee to Maternity Voices Partnership (MVP) in line with other groups in England. It is not clear how the MSLC/MVP links in with, or is responsible to other parts of maternity services structures and processes. A Trust maternity oversight presentation in March 2017 included a priority to strengthen the MSLC/MVP.

Friends and family test (FFT) response rate for maternity in 2015 were 10.9%. *FFT* scores are regularly discussed at patient experience group meetings as they have been low throughout the Trust. The Trust has introduced a texting option in an attempt to increase response rates, but has actually found that they have fallen. The Trust maternity action plan for 2017 proposed that by the end of July 2017,

existing patient feedback data should be widely shared within the maternity team, including FFT comments, complaints and compliments. It should include visibility of weekly FFT comments to delivery suite staff, sharing of complaints with the full team, and sessions to identify lessons learnt and changes arising from these. The assessors did not see evidence of this during their visit. In addition, the action plan suggests the running of a local 'Whose Shoes' event to ensure that the team hears the voice of women using maternity services. One of the inpatient ward managers had introduced 'comfort rounds' to ensure women have everything they need, such as drinks and analgesia.

11. CONCLUSIONS IN RELATION TO TERMS OF REFERENCE

Having had the opportunity to review the service at Walsall it is apparent that the service is on a journey. The CQC report in 2015 rated the service as inadequate and this appeared to be a shock to the Trust, demoralising the staff. The CQC report suggested that the culture and behaviours within the unit posed an obstruction to change, were oppressive and at times, jeopardised governance processes. Following this report, several changes in the senior team occurred. However, it took a long time to establish a new leadership team. This unstable period of leadership did not assist the Trust with moving the maternity service forward and was critical to the lack of improvement. A new team is now established and works cohesively in a positive and supportive manner. Although it is a great challenge for this new team to take all staff forward with them, many improvements have been made already.

Examples of the improvements which have occurred include:

- capping of births despite a difficult financial climate
- formation of a new midwifery senior management team
- improvement in the midwife: birth ratio
- new enthusiastic senior team in place
- plans for mentorship of the acting CD in place
- theatre practitioners now working in obstetric theatres rather than midwives
- agreed plan for second obstetric theatre
- midwifery lead for normality in post
- new equipment to support the normality agenda
- almost all guidelines now up to date
- governance structure strengthened and risk management midwife in post who is respected and supported by the consultants

- daily reviews of caesarean sections resulting in a reduction in the LSCS rate
- engagement project and open meetings
- a passionate, loyal and committed team.

1. Identify the organisational issues facing the service, with particular focus on medical and midwifery staffing to ensure safe provision of maternity services.

Midwifery **staffing**

Midwifery staffing has greatly improved with the capping of births. The main challenge at present is the high sickness and vacancy rates. To improve this, there is ongoing recruitment and the service has been authorised to over recruit. However, with the high turnover rate, it is anticipated that there may still be vacancies following this round of recruitment. The culture, multiple changes, lack of clear communication and the effect of the CQC rating has led midwives to consider their employment status with the Trust. The closure of the MLU, while assisting staffing levels on the delivery suite, runs the risk of losing the very midwives needed to drive the normalisation agenda forward. The Trust needs to ensure the forward looking plans for the MLU are clearly communicated and demonstrate how they value these individuals in order to retain them. The high levels of sickness should be addressed in conjunction with human resources.

Medical staffing

The leadership team needs to decide whether consultant time is being used in the most effective way to improve safety within the unit. Consideration should be given as to whether 142.5 hours of consultant presence is deemed necessary. The assessors accept that the Trust or CCG may feel it is inappropriate to reduce the level of consultant presence in a unit where safety concerns have been expressed. If this is the case, consideration could be given as to whether it is necessary to have a second consultant on call from home; or alternatively, whether this could be provided in a different way, for example, with nonresident consultants on call from home 1 week at a time or remunerated for each time they are called in (as happens in some other specialties e.g. vascular or gastroenterology).

At present, four of the consultants are locums. Forthcoming substantive appointments will stabilise the workforce and enable development of certain aspects of the service.

Job plans require review. The allocation of SPAs is generous and should be designated to specific activities, such as mandatory requirements, governance activities and leadership roles. Consideration should also be given to making SPAs outcome based. No time is allocated within job plans for patient administration (a DCC activity) and the assessors learned that this is completed within SPA time. It would be appropriate to re-designate some of the SPA time as DCC time for clinical administration.

The expectations of any role should be explicit; consultants should be supported in their roles, but also held to account for meeting those expectations.

2. Identify areas of clinical practice that are not based on current best practice or national standards, and advise of approaches to enable the implementation of change.

There are several areas that can be identified as not reaching best practice. Most of these are known to the Trust and work has commenced on these, for example, reducing the caesarean section rate and the introduction of the normalisation agenda. It is believed that daily review of caesarean sections at the safety huddle has effected this improvement. The introduction of a VBAC clinic and a birth afterthoughts service should assist in the further reduction of this rate.

3. Review intervention **rates** and **suggest ways to** reduce **inappropriate** interventions, in line **with** the **normality agenda.**

It is positive to see that a midwife has been identified to lead the normalisation agenda initiative, but this will require support from all members of the team. In order to ensure the retention of midwives who specialise in this area, it is imperative that the Trust communicates clear plans on the reopening of the MLU and the development of a MLU alongside the CIU. Currently, only small numbers of women use the pool during labour. Further training in the use of the active birth beds and pool for labour and birt h is required for midwives and doctors to ensure all staff feel comfortable with this choice for women.

The daily review of LSCS should continue and the work which is planned to extend the normality pathways into the antenatal period should be supported.

4. Review the clinical governance arrangements that are in place to ensure a safe and effective maternity **service.**

Work has been done to strengthen the governance arrangements within the unit and this has been improved by having a mid wife as well as the risk midwife within the governance team. Both have been commended for taking this forward. There is still, howeve,r the attitude that governance should be done by the governance team rather than the maternity service, who should ultimately take ownership and responsibility. The incident review process does not appear to be generally well understood, with senior team members having litt le clarity about the issue. Responsibility for action plans should be that of the clinical team and not the governance team, in addition to ensuring actions are completed in a timely manner before the same issue recurs.

Clinicians with roles within the governance structure need to have a clear understanding of their roles and responsibilities, and be prepared to be held to account for these, as well as to hold others to account when necessary. Some of the more junior clinicians with governance roles require support, mentorship and leadership development. Governance meetings within the maternity unit and at the divisional level need to become more effective, and the risk registers should be reviewed to ensure that they provide the board with a true reflection of the risks.

5. Review the culture, leadership capability and behaviors within the maternity unit conducive to effective team working.

Although there have been changes within the culture, there are still several members of staff whose behaviours are divisive and not conducive to a supportive team working environment. No concerns were expressed about the clinical skills of these individuals, but their attitude to colleagues is inhibiting the care provided as junior staff may be reluctant to ask for advice. A very good piece of work has been undertaken by the Trust looking at behaviours, which needs to be accepted and adopted in order to move this aspect of the service forward. At the present time, staff feel that nothing is being done to tackle the behaviour exhibited by some senior staff who are perceived as being immune from criticism or sanction.

The present senior team is working cohesively and supportively with staff to try to identify obstacles to moving the service forward. At present, the actions are transactional rather than transformational. The acting CD and the HoM appear to have gained respect from their teams with their enthusiasm and energy, but the teams are aware of their relative inexperience within senior management posts.

Consultants who currently hold leadership roles, such as the labour ward and governance leads, within the department do not appear to have an understanding of what is expected of them within their role or how to lead that aspect of the service.

6. Identify barriers to, and facilitators of sustainable improvement

The barriers to sustainable improvements are associated with the culture of the unit, which is traditional and hierarchical, and has inhibited change. The temporary closure of the standalone MLU could have been used as an opportunity to progress the normality agenda on the hospital delivery suite. Instead of valuing the skills of the community and MLU midwives, and using this as an opportunity for learning, the traditional hierarchical approach has resulted in these midwives feeling demeaned and seeking employment elsewhere.

Tackling the poor behaviours of some consultants has resulted in resentment and disengagement. However, the experience of these individuals could be valuable if they would agree to support other more recently appointed consultant colleagues who have leadership roles for particular aspects of the service within the department, for example, the labour ward and obstetric governance leads.

There are many staff who are passionate in their roles and wish to see improvements to ensure an excellent service. However, until this change is embraced by all staff, sustainability will be at risk.

Positive action has been taken by the Trust by capping the number of births to a sustainable level according to the physical attributes of the service and most importantly, the staffing levels. The Trust has recognised that increasing deliveries is not a positive action if it cannot be resourced appropriately and the Trust is to be commended for this action.

7. Provide recommendations where appropriate with the aim of improving care for women and their babies.

See the recommendations outlined below in Section 12.

12. RECOMMENDATIONS

Organisational

12.1 Continue to cap births to a level that is sustainable by the Trust to ensure safe and quality care for women.

12.2 Ensure processes are in place so that requests for information from organisations such as CQC can be provided in an accurate and timely manner.

12.3 Review the level and timing of resident consultant presence and whether there is a need for a second consultant to be on call from home out of hours.

12.4 Consider whether all posts should have some resident out of hour and on call duties to dispel any perceptions of a two tier consultant grade. Resident out of hour duties do not necessarily need to be overnight, they may be in the evenings or during the day at weekends.

12.S All appropriate staff must be granted time to attend meetings, particularly the delivery suit e forum, maternity risk management and PROMPT training, but this is not an exclusive list.

12.6 In the antenatal clinic ensure that either the number of women attending is reduced, or that an appropriate level of medical cover is arranged, when consultants are on leave.

12.7 Develop a structured maternity improvement action plan, with appropriate timescales, to enable changes to be introduced and embedded in a planned and incremental way.

12.8 Create a clinical breastfeeding lead post within maternity services.

Culture

12.9 Review, acknowledge and implement the work undertaken by the staff engagement lead in relation to cultures within the unit.

12.10 Schedule open meetings on a regular basis to facilitate interaction between senior managers and other staff.

12.11 Rotate core midwifery staff between wards and establish inclusive team leader meetings to he,p reduce tensions between the delivery suit e and inpatient wards.

12.12 Praise, recognise and reward inclusive and supportive behaviours. This could be by email. inclusion in a newsletter, or a weekly, monthly or annual award.

Leadership

12.13 Progress the plan to provide support for the acting CD in the form of external mentorship and internal support from the Medical Director.

12.14 Support the HoM with mentorship from an experienced HoM and/or senior nurse.

12.15 Facilitate attendance by HoM at regional and national HoM meetings to enable access to peer support.

12.16 Appoint a deputy HoM to support the HoM during the change process and in the longer term.

12.17 Clearly outline the roles and expectations for all consultants in a leadership position within the maternity service, for example, for the labour ward and obstetric governance leads.

12.18 Extend the leadership development programme to include programmes for new consultants or aspiring leaders.

Communication

12.19 Continue open meetings to ensure all staff are advised of any developments in a timely manner. Regular listening events should be facilitated by a source external to the directorate, but with the option for a divisional representative to be present for part of the meeting for feedback when appropriate.

12.20 Urgently communicate plans in relation to the MLU and the sustainability of the Walsall maternity service to all staff to prevent midwives seeking employment elsewhere. Local women should also be made aware of the birthing choices available to them.

12.21 Action plans referring to planned changes should be made available to all staff.

Management

12.22 As the key output of appraisal, all staff should share personal development plans with line managers.

12.23 Review consultant job plans and clearly designate SPA time. Consultants with leadership duties should have an appropriate amount of SPA time allocated. Consultants who do not have leadership duties may require fewer allocated SPAs in their job plan.

12.24 Re-designate time spent on clinical administration as DCC time rather than SPA time.

12.25 Midwifery managers should address sickness rates as a priority by working in conjunction with human resources.

12.26 The Trust should identify and support Professional Midwifery Advisors in line with A-Equip or an alternative model.

12.27 Allow a more flexible approach to midwives requesting to reduce their hours of work to improve retention of staff.

12.28 The midwifery leadership team should ensure that there is a shared understanding of the acuity tool, so that midwives themselves can see its utility in redeploying staff appropriately within the maternity unit.

Women-focused care

12.29 The Trust should consider how to provide a copy of the computerised labour and birth records to any women who request them.

12.30 Support the MVP to develop. The final ToR should be agreed and the patient relations team and communications department should support the MVP by advertising its services to encourage the recruitment of more service users.

12.31 The MVP should take up the offer of the CCG to pro vide resources to facilitate its development.

Clinical governance

12.32 Ownership and accountability for governance should rest within the maternity service. Mentorship should be provided to the divisional and obstetric governance leads to help them understand their respective roles and responsibilities. They should hold others to account and be accountable themselves.

12.33 Serious incidents should be investigated by following the best practice described in the Serious Incident Frame work[4]. It should be done by a multidisciplinary group including a midwife and a Consultant, using RCA techniques. This should be overseen and supported by the risk midwife. Ensure externality on the SI review panel.

12.34 The Trust should define what training is required to conduct an investigation into a serious incident. It should compile a list of investigators (midwifery and medical) with the appropriate training.

12.3S All consultants and senior midwives (Band 7 and above) should be trained in incident investigation techniques.

12.36 All staff should have a full understanding of the serious incident review process. Staff should be provided with a brief description of the process when statements are requested, tabletop exercises are undertaken or when the findings from incidents are fed back.

12.37 Ensure a recognised system of support is in place for any staff involved in a serious untoward incident.

12.38 Improve the rigor of the quality assurance process for incident investigation (RCA) reports. Consider the involvement of a senior obstetrician with governance experience or an external reviewer.

12.39 Track and complete action plans in a timely manner and identify a responsible clinician to reduce the chance of recurrence. This should be the responsibility of the maternity service and not the governance team.

12.40 The audit lead should ensure that the audit process is followed, standards are defined at the outset and measured, and that specific actions with timescales are planned. The maternity unit should develop systems for identifying areas where practice or outcomes in Walsall are worse than the national rate, for example, by using MBRRACE, Getting it Right First Time and Each Baby Counts reports, as well as statistics from the RCOG National Maternity and Perinatal Audit report[2] published in November 2017.

12.41 Audits within the maternity unit need to be effective to enable the Trust to identify where practice is not complying with standards and implement change. It will also enable the Trust to demonstrate improvement. Audits must also include changes within the midwifery arena involving midwifery staff as well as obstetric.

12.42 Guidelines should continue to be updated on a regular basis or whenever there is any national evidence, for example, NICE guidelines, which may affect a particular guideline. There should be a process for prospectively identifying which guidelines will be due for update.

12.43 Develop a process for tracking action plans from complaints. Any outstanding actions should be reported back to the relevant forum.

12.44 Review risk registers to ensure that the maternity and divisional register concord, and accurately reflect the risks and mitigation. Any resolved risks should be removed.

12.45 Continue to monitor postnatal readmission rates via the maternity dashboard, instigating review of cases and actions if these rise above a threshold decided by the governance group (suggested threshold of 4%).

12.46 Include delays in decision to delivery interval, amniotomy and elective LSCS on the maternity dashboard.

Normalisation of childbirth

12.47 Define the criteria which need to be met for the reopening of the MLU and publicise this to staff and women.

12.48 Clearly identify women receiving midwifery-led care on the delivery unit white board.

12.49 Staff should be encouraged to take lead roles in various normalisation processes.

12.50 Recruit and identify a midwifery lead for normality to develop antenatal pathways that ensure low-risk women are identified and receive midwifery-led care in labour. A process should also be developed where women who have a complication that is then resolved return to the midwifery-led pathway.

Training and development

12.51 Increase the midwifery and administrative support for the Practice Development Midwife in order to ensure any backlog is cleared. Establish regular training, and skills and drills sessions.

12.52 Develop training plans for any new major equipment that is introduced, such as cell salvage and active birth beds.

12.53 Keep records of accurate training statistics. This may require administrative assistance.

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 Assessor & e-sig.	**Date 22 January 2018**
Dr Assessor & e-sig.	**Date 22 January 2018**
Midwife Assessor & e-sig	**Date 22 January 2018**
Lay Representative & e-sig	**Date 22 January 2018**

14. REFERENCES

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APPENDIX 1: TIMETABLE

WOMEN'S, CHILDREN'S & CLINICAL SUPPORT SERVICES

RCOG Review

Wednesday 4th October 2017 09:00-16:30 delivery suite

Time	Agenda,Item	, Lead: Names Redacted
08:30	Chief Executive/Medical Director	
09:00 - 09:30	Meet and greet/Tea and Coffee	
09:30 - 10:00	Tour of the Unit	
10:00 - 10:30	Review team to discuss	
10:30 - 11:OO	Director of Operations (Divisional Manager)	
11:00 - 11:30	Labour Ward Lead Midwife	
11:30 - 12:00	Divisional Director (Clinical Lead)	
12:00 - 12:45	**Break**	
12:45-13:30	Clinical Director Obstetrics (Deputy)	
13:30 -14:00	Labour Ward Lead	
14:00 -14:30	Divisional Director of Midwifery	
14:30-15:00	Matron (s)	
15:00 -15:30	Review team to discuss	Review Team
15:30 - 16:00	Clinical Governance Lead/ Midwifery Risk Management	

WOMEN'S, CHILDREN'S & CLINICAL SUPPORT SERVICES

RCOG Review

Thursday Slh October 2017 09:00-16:30

Time	Agenda Item	Lead
08:30 - 09:15	Obstetricians	Consultants
09:15- 10:00	Junior Obstetric Doctors	Junior Doctor
10:00-10:30	Professional Midwifery Advocates	Governance
10:30 - 11:00	Band 7 Midwives & Team Leaders	Band 7's Team Leaders
11:00 - 11:30	Review team to discuss	Review team
11:30 - 12:00	Band 5 and 6 Midwives & Student midwives	Midwives
12:00 - 12:30	Obstetric Speciality Education Lead (Tutor)	Obstetric Ed Lead
12:30 - 13:15	**Break**	
13:15 - 13:45	Clinical Governance Lead for Obstetrics	Obstetric Consult
13:45 - 14:15	Service Users and PALS representative	PaLs Lead/ Service Users
14:15 - 14:45	Midwifery Education Lead	CPD Midwife
14:45 - 15:30	Review team to discuss	Review team
15:30-16:00	Feedback with Medical director, Director of Nursing and Chief Executive	Medical Director, Nurse Director and CEO

APPENDIX 2: ASSESSOR COMMENTS ON RCA REPORTS

Case 1:

The author writes in root causes: No significant factors as to the root cause of this incident have been found.

The assessor's view: This was undiagnosed intrauterine growth restriction and delay in performing caesarean section (birth weight, 2.210 kg at 40H weeks of gestation).

Decision to perform caesarean section should have been made at 14:10 hours rather than at 14:30 hours.

Case 2:

The author writes in root causes: No significant factors as to the root cause of this incident have been found.

The assessor's view: The root cause of this woman's condition was the ruptured ectopic pregnancy due to delay in diagnosis. Decision to take the woman to theatre should have been made at midday as she was symptomatic and had suboptimal rise in beta human chorionic gonadotrophin. Even when the case was discussed with the consultant at 23:35 hours on the same day due to concerns raised by the nurse, that woman continued to have pain despite regular analgesia. The advice of the consultant was to continue with analgesia as nothing further would be done that evening and to increase the administration of Oramorph® to hourly if needed. In the opinion of the assessors, the consultant should have reviewed the woman with a view to take her to theatre. However, as the woman was stable and if the consultant did decide to leave her overnight, the consultant should have proactively ensured that she did go to theatre the next morning. Not only was there no consultant review on the night, there was no plan of care made and no consultant-to-consultant handover occurred on the next day. The woman was requiring repeated doses of Oromorph® over the two days and did not go to theatre until the third day after a diagnosis of ruptured ectopic pregnancy was made on the scan at 10:00 hours.

The report comments on the role of junior doctors, but fails to comment on the role of consultants in the ongoing management of the ectopic pregnancy. In a unit with 4200 births and 142 hours of consultant presence, it is unacceptable that there is no review of sick patients on the gynaecology ward on a daily basis.

Other comments:

1. Although the reports on two obstetric serious incidents comment on the clinician's opinion of the cardiotocography and whether it is normal, suspicious or abnormal, there is no comment by the author whether they agreed with the interpretation or not. A comment should be made by the author regarding the interpretation.

2. The same applies to various actions taken during management of labour.

APPENDIX 3: BIOGRAPHIES

2 pages of Personal Work Biographies of RCOG assessment team have been redacted