REPORT

Review of the Obstetrics and Gynaecology Services at North Devon Healthcare NHS Trust

On 27–28 September 2017
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1. EXECUTIVE SUMMARY

This is the second review by the Royal College of Obstetricians and Gynaecologists (RCOG) commissioned by the North Devon Healthcare NHS Trust (NDHT). The first review, which took place in 2013, highlighted difficult working relationships within the maternity department with the potential to affect patient care.

This review was requested following a series of clinical incidents, and the assessors were also tasked to evaluate the relationships between medical and midwifery staff. The review also aimed to assess the clinical governance processes that follows clinical incidents, in terms of escalation and the quality of the investigation, as well as staff adherence to (and quality of) the local clinical guidelines.

The assessors found that staff at all levels were willing to engage in the review process. Working and interpersonal relationships appeared to be a major issue within the unit and had broken down at multiple levels. This was particularly evident between medical and midwifery staff.

Medical staff (particularly at consultant level) appeared deskilled, demotivated and over reliant on a single colleague for all nonclinical leadership aspects of the running of the unit. The consultants seemed reluctant to follow guidelines, unwilling to cooperate with each other and unhappy to accept (even constructive) challenge from midwifery colleagues.

By converse, a majority of well-motivated and progressive midwives seemed driven to act as advocates for women, in the attempt to guarantee their safety.

Working patterns, job planning and clinical governance processes (unwittingly promoting a blame culture) also appeared to play a major destabilising role.

The assessors have made recommendations that they hope will be constructive and help to improve the care provided to women and their babies.

2. INTRODUCTION

This review has been commissioned by Dr George Thomson, Medical Director of NDHT, to assess the obstetrics and gynaecology services based on information provided by the Trust and on interviews undertaken during the visit.

3. NAMES OF REVIEW TEAM MEMBERS

Lead Assessor:
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Co-Assessors:
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4. REASON FOR REVIEW REQUEST

Following a series of significant clinical incidents, the Trust commissioned an ‘Invited Review’ by the RCOG in November 2013. With the exception of suggesting a few changes in clinical practice (including the discontinuation of amniocentesis at the hospital) the report focused on the complex working relationships within the department and suggested an action plan for resolution.

Following receipt of the report, the Trust executive team, including the Head of Midwifery (HoM) and Clinical Lead for obstetrics and gynaecology, decided not to share the full version with their staff. An edited and redacted version, prepared by the Trust, was circulated instead. Although the aim of this was to remove details that could have led to the identification of those who had made various statements and to protect their anonymity, most obstetricians who were interviewed took it as an attempt to cover up certain findings, preventing them from becoming public.

The Care Quality Commission (CQC) visited the Trust in July 2014 and rated the Trust as “requires improvement”, with the Department of Women’s Health rated as “good”. In the CQC report, there were frequent references to the previous RCOG report and to the fact that that the long standing and complex problems surrounding the interactions of the medical team could impact on patients’ safety. There were also references to the lack of consultant input in guideline development, absent approach towards the rates of caesarean section and induction of labour, and variable level of presence in the running of the labour ward and to the demands of the governance structure.

The Trust set in place numerous team bonding and team building exercises that took place in the 12 months following the report and that, on the whole, were well attended.

A further CQC review in August 2015 rated the maternity unit as “requires improvement” and found that the working relationships between the medical and midwifery teams had improved, but that more focused work was needed to ensure cohesive teamwork.

A further cluster of recent serious incidents in maternity has led the Medical Director at the Trust to request this second review by the RCOG. Although the medical staff work across the obstetrics and gynaecology services, the trigger episodes for the review request were all obstetric in nature.

5. TERMS OF REFERENCE

1. To analyse a series of serious untoward incidents (SUI) and, in those cases, assess the clinical decision making and clinical governance processes.

2. To assess team interactions, communication and dynamics, as well as the potential impact on patient safety and outcomes. Potentially critical issues surrounding communication between clinicians, whether formal (i.e. handover and escalation) or informal will also be assessed.

3. To assess if current clinical guidelines and standard operating procedures are up to date, comprehensive and easy to follow, and if they are adhered to.
4. To review the clinical governance processes in relation to whether:

- Team dynamics are conducive to a climate of openness, and facilitate the escalation of problems and reporting of incidents.
- Investigation of incidents is a fair and non-threatening process, and ultimately results in shared and constructive learning.
- Learning is undertaken and embedded as a result of any incident or event, and there is clear evidence of this.

5. To make recommendations on how potential problems in care delivery, team working and governance structure can be overcome.

6. To make recommendations to the Trust based on the findings of the review team and anything else that comes to light.

6. CONTEXT

NDHT is a small hospital (341 beds) serving a very rural (1300 square miles) and dispersed population of approximately 160,000 people in North Devon. Geographically, it is quite isolated; 44.4 miles (1 hour 12 minutes) from Exeter via the link road and 62 miles (1 hour 54 minutes) from Plymouth, the nearest centre for neonatal intensive care. In 2016/17, the Trust treated 28,122 inpatients, 21,804 day cases and 353,650 outpatients. Although the Trust is small, it has networks with Musgrove Park Hospital in Taunton for vascular services, the Royal Devon and Exeter Hospital for gynaecological cancer and Plymouth Hospital for level 3 neonatal care.

During 2016, under the leadership of the STP, a sustainability and transformation plan was developed for Devon in response to a massive financial deficit across the Devon health sector. The aim was to develop proposals to deliver a safe, financially sustainable and integrated service for the whole of Devon between 2016/17 and 2020/21. In response, an acute services review was conducted, including the provision of maternity and paediatric services across Devon. A commitment was made to maintain four consultant-led maternity units (CLUs). However, the configuration and working practices may alter and change within each unit with time. Within Devon currently, 89% of births take place in CLUs. There is one co-located midwifery-led unit (MLU) and four standalone MLUs, but none are in close proximity to NDHT.

In the financial year between April 2016 and March 2017, 1530 women gave birth within NDHT maternity services, the majority at Barnstaple hospital, with an above average homebirth rate of 3%. The caesarean section rate was 30.4% (12.8% elective and 17.6% emergency cases) and labour was induced in 24.2% of women.

NDHT runs a CLU and women with significant and recognised high-risk factors that could adversely affect their labour outcome are directed towards Exeter or Plymouth hospitals in advance.

In line with a geographically isolated unit, in which some high-risk women will be transferred in advance of birth, there were six cases of perinatal mortality (3.89 per 1000) for the year which included four stillbirths.
The Trust provides comprehensive gynaecological services, including inpatient, day case surgery, colposcopy, hysteroscopy and urogynaecology investigations. A termination of pregnancy service is also provided to the community. Cancer services are supported by the network, based in Exeter. The majority of the consultants appear more motivated by this area of work and express pride in complex urogynaecology and laparoscopic surgery.

The obstetrics and gynaecology services are under the umbrella of the Women's and Children's Directorate, having previously been part of the surgical directorate. The current Clinical Director is a paediatrician.

The hospital has an 18-bed maternity ward, six labour ward rooms (including a birthing pool) and a day assessment unit (on Bassett Ward). There is one single obstetric operating theatre (to be shared between elective and emergency procedures).

The obstetric consultants cover labour ward on ‘hot weeks’, starting on the Friday morning, and they are job planned to be present on the labour ward for 40 hours per week. During the ‘hot week’, the consultants also cover gynaecological emergencies as well as the early pregnancy assessment unit. This is also a continuous week of emergency cover out of hours, which was instigated to try and improve the continuity of patient care. Following this ‘hot week’, the consultants are free of any clinical responsibilities for the totality of the following week. They are supported by a career middle grade doctor (Trust grade) and a senior house officer (ordinarily a general practice vocational trainee) with a single specialist trainee (year 1).

The labour ward has 24-hour obstetric anaesthetic cover (and epidural service).

The special care baby unit at Barnstaple Hospital is designated as level 1. Level 3 neonatal care, if required, is provided by Plymouth or Bristol hospitals.

7. CONSULTANT STAFFING

There are six consultant obstetricians and gynaecologists in the department:
8. DESCRIPTION OF REVIEW PROCESS AND SITES VISITED

During the visit the assessors had the opportunity to undertake a guided tour of the unit at Barnstaple Hospital. The interview schedule can be found in Appendix I.

9. DOCUMENTATION SOUGHT FROM THE TRUST

Prior to the visit the assessors had requested the following documentation:

- Copy of the medical record of the index cases (SUls), including cardiotocograph (CTG) traces.
- Copy of internal risk management investigations and root cause analysis reports.
- Information on staffing levels and working arrangements (medical rotas and midwifery shifts) within the unit.
- Management structure and overview of the service.
- Maternity workload statistics and dashboards.
- List of available guidelines, including review dates.
- Copies of sample clinical guidelines: management of the labour ward; normal labour; fetal monitoring; normal and abnormal progress in labour; preterm delivery and rupture of the membranes; pre eclampsia; and obstetric haemorrhage.
- Guidelines regarding governance issues and structure, and clinical risk investigations.
- Copy of any CQC reports.
- Clinical risk reports: data on complaints and their resolution, number of SUls and legal cases.
- Any data on benchmarking to other units so far taken into consideration.

All, with the exception of the complete medical records related to the index cases, were provided. The index cases documentation, which consisted of the reports of the internal investigations, was however extensive and exhaustive.

The assessors also received a copy of the previous RCOG invited review report from 2013, as well as the redacted version from the Trust. During the visit, medical records relating to further clinical incidents were shared with the assessors by various members of staff.

10. SYNOPSIS OF INDEX CASES AND CONCERNS

Four clinical incidents were submitted to the assessors prior to the review.

10.1 Case 1

A 25-year-old woman in her first pregnancy was admitted at 37\textsuperscript{1} weeks of gestation with shortness of breath, a respiratory rate of 28 breaths per minute and metabolic acidosis (lactate 9.4 mmol/l). There was significant elevation of liver enzymes. The woman progressively deteriorated and became hypertensive. Serum lactate further increased and the woman became subjectively unwell and all vital signs deteriorated. It was not until 30 hours following admission, and following anaesthetic involvement (when a caesarean
section had been decided), that the seriousness of the woman’s condition was fully appreciated. The woman was transferred to the liver unit at King’s College Hospital, London, via air ambulance after stabilisation where she gave birth safely.

The RCOG assessors were concerned with the delay in appreciating the seriousness of the presentation, and that the patient was clearly and progressively deteriorating.

The internal investigators of the case stated that they were also concerned with the documentation and lack of multidisciplinary approach and incongruent planning.

10.2 Case 2

A woman in her second pregnancy (with a history of a previous vaginal delivery) was induced at term for a history of reduced fetal movements.

Progress in the first stage of labour arrested at 5 cm dilatation and the woman was started on a Syntocinon® infusion. The woman experienced increasingly more severe abdominal pain despite epidural analgesia. The woman also became tachycardic, pyrexial and developed a mottled leg.

The CTG trace progressively deteriorated and fetal blood sampling was performed. This gave a reassuring result. When the CTG became pathological, a category 1 caesarean section was performed and this revealed a ruptured uterus. As a consequence, the woman suffered a major haemorrhage (2700 ml) and the baby, who suffered hypoxic ischemic encephalopathy insult, had to be transferred to Plymouth hospital for level 3 neonatal care.

The internal investigation determined the following root causes:

1. Failure to recognise the significance of the combination of the vital signs and symptoms of the mother and baby, and the deteriorating conditions during labour due to a singular reliance on the CTG and fetal blood sample to the exclusion of other indicators.

2. When it became apparent that the situation was serious, the staff grade failed to escalate this to the consultant in line with maternity services operational policy.

3. Communication from the midwives to the staff grade was not sufficiently assertive to ensure that the staff grade took action to escalate. The midwives did not then escalate to the consultant.

The medical records and the CTG for this case were shared with the assessors during the visit. The assessors felt that, given the rarity of uterine rupture in the absence of previous uterine scars, it would not be reasonable to expect the clinicians involved to promptly suspect and predict such an event.

However, there was a clear delay in reacting to a pathological CTG. This was deteriorating very severely and, under the circumstances, it was felt that relying on a single fetal blood sample was substandard practice.
There was also no attempt to interpret other significant clinical signs or to escalate to more senior clinicians.

10.3 Case 3

A 32-year-old woman who had given birth 16 days previously called 999 for an ambulance due to central chest pain and a feeling of “impending doom”. Upon transfer to the ambulance the patient collapsed and suffered a cardiac arrest. Despite prolonged resuscitation, the woman never regained a cardiac output and was pronounced dead at the emergency department of NDHT. The postmortem examination revealed coronary atherosclerosis.

The assessors did not have concerns on the management of this case.

10.4 Case 4

A woman in spontaneous labour was augmented by artificial rupture of the membranes and Syntocinon® infusion at 5 cm dilatation. The woman became pyrexial (38°C) and the fetal heart rate became progressively tachycardic. The woman was treated initially with intravenous fluids and was later prescribed intravenous antibiotics.

At 9 cm dilatation, a category 2 emergency caesarean section was decided. It was a difficult delivery and the baby was born in poor condition. The baby was intubated at 14 minutes of life, was treated with antibiotics and had to undergo two rounds of cardiac resuscitation. Excessive blood was noted in the endotracheal tube. The second round of cardiopulmonary resuscitation had to be abandoned due to lack of success and the baby was pronounced dead.

The postmortem investigations noted the cause of death as:

1a. massive pulmonary haemorrhage
1b. sepsis
1c. acute chorioamnionitis.

The assessors were gravely concerned with the quality of the SUI investigation that had inexplicably concluded “no root causes were identified as a result of the investigation and none were recorded in the postmortem report, which was inconclusive”.

It was clear to the assessors that the baby had suffered massive pulmonary haemorrhage, secondary to disseminated intravascular coagulation, as the result of sepsis. Given that the assessors could only view the investigation report, which was substandard in quality, and none of the actual medical records, no conclusions could be drawn on the quality of care provided in this case.
11. GENERAL FINDINGS

11.1 Staffing

The assessors were impressed with the level of commitment, enthusiasm and pride the midwifery staff at all levels demonstrate for the unit.

Structurally, the unit appears to be in good order and well appointed. The midwives (individually and within each focus group) appear to work well as a team and to hold good working relationships with managers at all levels. The midwives are confident in reporting concerns and escalating difficult situations. Such an attitude had taken the senior management team some time to instill and relationships between the midwives and current managers had not always been so satisfactory. The midwifery staff seem particularly motivated in acting as advocates for women and are obviously prepared to be outspoken if they feel that anything could compromise the care of the women.

However, it is clear that there is a deep sense of concern among the midwifery staff regarding the quality of care sometimes provided within the unit. Many of the midwifery staff noted they themselves would book at alternative providers rather than give birth in this unit. Some of the comments were shocking: “is this the shift that I will lose my registration”, referring to anxieties about an inability to counteract consultant-based decision making and being responsible for their failure to respond in an expected manner to crisis situations – “Why are you questioning me? I am a doctor”. Such an authoritarian and disrespectful attitude does not facilitate team building and professional confidence.

Apart from the four index cases described above, frequent references were made to two further cases with very poor neonatal outcomes that had occurred more recently. These two cases were not shared by the Trust with the assessors in advance to the visit: i) because of active medico legal proceedings; and ii) because the events were so recent, an internal investigation had not yet taken place.

Although the assessors were unable to draw firm conclusions on the management of the two additional cases, some of the themes highlighted by midwifery staff at all levels were comparable to those identified in the index cases provided. These included a lack of appreciation for the severity of the clinical presentation and a deteriorating picture, as well as a delay in intervention, seemingly due to a lack of confidence in dealing with real-life obstetric emergencies. Indeed, such degrees of inaction raise serious issues of competence and the ability to make appropriate decisions.

Generic concerns were also expressed on numerous occasions and it was reported that most consultants have lost confidence in dealing with clinical emergencies within the labour ward. Although there are normally 40 hours per week of consultant cover for the labour ward, most consultants appear reluctant to deliver care and are inclined to leave the staff grades or career doctors in charge of difficult cases. In one of the incidents referred to above, the consultant on-call, after having attended and contributed to the diagnosis, had physically left the room while the middle grade doctor undertook the delivery. This resulted in a very tragic outcome.
One of the obstetric consultants was reported to have undertaken only one delivery over the previous 12 months. It was quoted “consultants have allowed staff grades to run this unit and it is only in the last 4 years that they have been phoned for decisions about caesarean sections when on-call”.

At night, consultant attendance to the labour ward is less than sporadic. Apart from any other consideration, the assessors felt that running ‘hot weeks’ in obstetrics, albeit in a small unit, cannot be conducive to prompt and frequent attendance during the night, as they are expected to attend 7 days in a row and also be available for emergency night time cover.

In addition to what appears to be a situation deriving from a lack of confidence, secondary to progressively reduced exposure to difficult cases, consultant attendance to mandatory training is poor (46%). The assessors were also concerned by frequent reports of poor adherence to guidelines compounded by an unwillingness to accept challenge if such noncompliance is brought to their attention. The same attitude seems to be shared by the middle grade doctors who were viewed as “covering up for the consultants”.

11.2 Organisational issues

The current midwife-to-birth ratio within the unit is 1:32 (Birthrate Plus®; August 2016). The maternity dashboard indicates that one-to-one care standards are being achieved.

Although current recommendations do not specify a set target, the 40 hours of consultant presence is in line with previous national recommendations for units with less than 2500 deliveries per year1,2 (which was the standard to be followed at the time when staffing levels in the unit were set). However, although consultants are timetabled for on-call activities independently, the assessors learned from many sources that their attendance and time spent on the labour ward is felt to be less than satisfactory, with the exception of two of the consultants.

There appears to be a huge amount of reliance from colleagues and the midwifery establishment for the Labour Ward Lead. In addition to the management role on the labour ward, the Labour Ward Lead is also responsible for all major managerial roles and responsibilities, including district tutor, guidelines development, clinical risk management, and audit and fertility leadership.

When some of the consultants were confronted with this, they had a minimal understanding of the importance of such roles, and the amount of time and commitment necessary to fulfill each of them. The assessors understand that gynaecology responsibilities are covered by other consultants, but there appears to be no sharing of the maternity responsibilities.

Although the review was commissioned with the aim to look specifically into the provision of maternity services, the assessors unavoidably gained some knowledge of the gynaecological services. There was a stark difference in attitude, knowledge and confidence from the consultant staff in this area of women’s health, and a demonstrable sense of pride in the service that they are currently providing in gynaecology compared to obstetrics.
The six consultants and seven specialty doctors working in the NDHT maternity services have responsibility for a “relatively small volume of work compared to most units in England”, but the assessors would challenge how efficient the current model of providing emergency cover is. It is difficult not to conclude that the status quo might appear very comfortable and financially rewarding with infrequent overwhelming workload pressures. The pressures and stresses of working in a remote unit related to other issues will be covered later, but include repetition of duties, professional isolation and deskilling in some infrequently occurring emergencies.

11.3 Midwifery leadership

The HoM has been in post for 7 years and has worked on a radical transformation of the working practices within the unit, from incident reporting, risk management and investigations, to updating guidelines. Attendance at governance meetings has improved greatly over time, as well as the empowerment of the midwifery staff in challenging decisions and behaviours of medical staff, when it is felt that deviation from accepted protocols and standards of care can adversely affect the care of women. This transformation has been recognised at all staff levels during the interviews. It has unavoidably caused upset, and the current situation is one of definite fracture between the medical staff and the HoM.

Consultants, in particular, seem antagonised by such change in their working environment. Overall, they expressed feelings of threat in their position of leadership and disempowerment. A ‘blame culture’ was referred to.

At the midwifery level, however, the situation appears quite different: the majority of staff interviewed seem to have welcomed and embraced the change. Midwives at all levels of seniority expressed confidence in their leaders, and communication channels appear to flow well in a climate of openness and transparency.

During the interviews, midwives noted the positive impact that midwifery supervision has had on midwifery leadership development and clinical practice over the past few years in the Trust. They felt that the strategy for the professional midwifery advocate needs to be agreed within their unit to continue to support midwifery practice and user engagement now that the statutory supervision of midwifery is no longer in place nationally.

The Trust has recently engaged a retired external HoM recommended by NHS Improvement who is working 2 days a week to undertake a review of the maternity services. The terms of reference are similar to the RCOG review. The report is expected the end of October 2017.

11.4 Consultant staff

On the surface, consultants appear to be a cohesive group and they reported good working relationships to the assessors. Triangulation has, however, shown a different picture, with quite considerable fracture and poor harmony.

The assessors were informed of numerous occasions when consultants have argued loudly in public places and inappropriately in front of patients. None of the consultants appear happy to make decisions for
women who are not booked under their care (apart from in an emergency) and each of them has their own individual management for various clinical situations. There seems to be no team spirit and often no professional respect.

Many of the consultants have worked at NDHT for many years, either directly as a consultant or as a staff grade before promotion to a consultant. The assessors were struck by the possibility of some consultants being 'burnt out' and hearing that some consultants are wishing for retirement. Placing these doctors in very acute situations like the labour ward may be inappropriate and there appears to be an urgent need for new workforce and enthusiasm. However, a hospital of this size cannot afford to have consultants not covering labour ward and therefore, other human resource strategies need to be explored. It was not clear to the assessors the degree of human resource and occupational health involvement to address the current behaviour of some doctors.

As a result, despite complaining of feeling disempowered by management, all except for one of the consultants have reacted by becoming disenfranchised, and relinquishing all managerial responsibilities and leadership roles. The only other consultant who embraced such leadership challenges of late stood down for personal reasons.

The assessors were informed about doctors undermining midwifery staff by discussing women’s clinical care in front of midwives, in their native language so not to be understood by the attending midwife.

Extended midwifery roles have never been developed and provides further evidence of the desire of the doctors to maintain the current arrangements.

Clinical risk processes are not seen as a way to improve care and learn from mistakes, but as a punitive system. Some use expressions such as “they sent a Datix [clinical incident report] form against me”, showing poor understanding of the fact that reporting is not against an individual practice, but a proactive constructive process. It is worth noting that only four incident reports were completed by medical staff over 1 year.

The very nature of obstetric practice in a small, low-risk unit carries a risk of progressive deskilling in complex procedures and difficult clinical situations. However, with one exception, all other consultants attempt to actively avoid personal exposure to labour ward work.

The consultant on-call rota is structured in ‘hot weeks’. Each consultant works for 7 days and nights consecutively, caring for obstetric and gynaecological emergencies. The mechanism for the cross cover of absence and sickness means that this limit is often surpassed; the assessors learned of a consultant covering 17 days in a row.

Although this is a small unit with a small number of births, such pattern of work is anachronistic, potentially dangerous and not conducive to active participation in clinical activities out of hours.
11.5 Middle grade staffing

There was only one post identified for specialist training (at ST1) by the deanery and the current incumbent was pleased with the clinical exposure and help that they had received from staff. The junior doctor was able to complete OSATS [objective structured assessment of technical skills] with a range of medical and midwifery staff supervision.

The remaining doctors providing care at this level were non-training doctors, either associate specialists, staff grades or specialty doctors. Like the consultants, many of these doctors have worked in this hospital for a long period of time and their major responsibility is providing immediate first-level care for maternity and gynaecological emergencies.

Despite their length of service, there is a reluctance to challenge consultants. One statement included the explanation “he [the consultant] is the captain of the ship”. Some felt that the working environment is not good, with a greater blame culture coincident with the appointment of the current HoM. The current attitude to a ‘no blame’ methodology for investigating SUI’s seems in itself to be a threat. There remains a complacent attitude by inferring that things do go wrong from time-to-time, rather than a constructive proactive challenge as to how things might improve.

11.6 Medical leadership

Under the new structure for Women and Children's services, the Clinical Director is a Paediatrician with significant experience. They have observed first-hand the obstetric staff directly during clinical duties. This appointment appears to be met with surprise by some of the consultants in obstetrics and gynaecology, but the reasons were not forthcoming. The assessors sensed that the current appointee will resolve many of the ‘process’ issues, such as job planning, but there needs to be a broader vision for the development of the service which is being discussed within the acute services review.

Historically, the lead clinician has always been an obstetrician. However, since the lead clinician relinquished office, the new system has emerged. The lead clinician was respected by the midwifery management and this feeling was reciprocated, but contentious issues, such as job planning, were not resolved during the tenure of this lead clinician and remain an issue. Some stronger leadership from the executive team is now apparent.

The newly appointed consultant obstetrician and gynaecologist is well respected by all and keen to lead. However, this consultant requires urgent support from the Clinical Director, the senior management team and indeed the Board. Otherwise, there is a real risk that this consultant will find alternative employment or suffer from the burdens of the considerable responsibilities. Their current job plan does not reflect the commitment to the maternity service.

The lack of clinical engagement and leadership among this group of consultants has resulted in poor professional relationships with the executive team and midwifery staff.
11.7 Team building

The previous RCOG report from 2013 identified several issues with team cohesion and interactions. It suggested that attempts at rebuilding relationships should be made. Following this recommendation, the Medical Director arranged for several external consultants to engage the team in team building exercises. Judging by the comments collected during the interviews with numerous staff members, such attempts appeared to have failed. Feedback from one consultant about their experience of team building with an expert who by background was a retired senior serviceman, was that, although the expert had never admitted defeat before, he did here.

Generally, comments on the team building experiences were disparaging and negative. In particular, there seemed to be little appetite for any further attempts at rebuilding a team spirit.

11.8 Job plans

The job planning process seems extremely problematic. Most job plans have not been reviewed for 3 years. This has recently led the Medical Director to issue a 90-day deadline with the aim to impose job plans. Despite this, there is currently no resolution. The assessors had the opportunity to scrutinise the most recent job plans (by which consultants currently work to). Most job plans are structured on a 6-week rolling rota: 4 weeks for elective work; 1 week for on-call activity; and 1 week for rest (no work).

Based upon the accepted system where each full-time consultant is available for work approximately 42 weeks of the year, each of the six consultants cover 7 ‘hot weeks’ per year. The result is that only 42 weeks of on-call are covered by routine hours in job plans. The assessors learned that the remaining 10 weeks are covered by the existing consultants during their weeks off, at premium rate. This arrangement for on-call activities, with no cross cover embedded in job plans, is unusual and expensive to run. Each night on-call is remunerated with a full programmed activity (PA), which is equivalent to 3 hours of unpredictable work (on average). The assessors were informed that call back to the hospital overnight is an exceptional occurrence that makes such allocation extremely generous.

Each job plan that has been assessed contains approximately 2.25 PAs that are to be performed at no specified time. In effect, this allocation is equivalent to 1 full week of work in every 6 weeks’ work, which in turn translates into consultants having full pay for the weeks during which they are off.

11.9 Clinical governance

The assessors were given the opportunity to analyse the Trust’s clinical governance structure. One major aspect of the Trust’s policy is the decision to assign investigators external to the department to the most serious incidents. Although this could bring the benefit of impartial and dispassionate analysis, maternity care is, in general, regarded as a stand-alone specialty in which healthcare professionals from different specialties have very little knowledge or understanding.

Although there is a clear and laudable attempt to involve obstetricians in the investigations by inviting them to attend ‘round-table’ sessions, the investigations are said to progress even in their absence.
The results can be quite stark, as demonstrated in case 4. The assessors had the opportunity to corroborate this view during the interviews with staff members, as well as through the scrutiny of clinical incident investigations, not specifically listed as index cases.

The assessors were concerned to learn that following the investigation of case 2, the maternity team did not fundamentally agree with the initial report conclusions. Although, the conclusions were conceptually wrong and did not respect basic obstetric principles, it took a considerable amount of time and discussion to agree amendments. The reason for this was not shared with the assessors.

The inclusion of the new Labour Ward Lead (consultant) on the clinical risk panel seems to have improved the quality of risk investigations quite drastically. Having reviewed a series of recent investigations of low level incidents performed at the directorate level, the assessors did not express concerns.

Duty of candour was undertaken, but this appears to be at the jurisdiction of the risk midwife and teams. In general, the consultant body are not involved in the initial discussion or feedback with a woman and her family after a trigger event and it is the midwives that undertake this role.

11.10 Clinical guidelines

On numerous occasions the assessors learned that medical staff are often reluctant to adhere to the unit guidelines, preferring to manage cases and clinical scenarios according to their own beliefs and experience. This behavior is often challenged by midwifery staff, which causes annoyance and disagreement between staff.

There are situations where adherence to guidelines is not appropriate because of variance in presentation or individual circumstances. However, adherence to guidelines and standard operating procedures, whenever possible, has to be encouraged as it allows consistency and familiarity with management at all levels within the team. Such concepts do not appear to be embedded in the medical team. They openly referred to guidelines as necessary only for midwifery staff and very junior doctors. There does not seem to be an understanding of the wider picture nor the major advantages deriving from standardised practice to patients’ care.

Subsequently, the assessors considered whether there are intrinsic flaws in the set of guidelines available within the unit, leading to loss in confidence and, in turn, poor adherence. However, assessment of the available guidelines showed that they are comprehensive. With the arrival of the new consultant Labour Ward Lead, the guidelines development has become a multidisciplinary process. Guidelines appear up to date and are easy to follow.

The assessors could not highlight any reasons as to why the guidelines should not be followed in clinical practice.

Over the years, involvement by the consultants into guideline writing has also been inadequate: there is only one senior member of medical staff that appears on the list of authors and the assessors were informed that currently, only the Labour Ward Lead is involved.
11.11 Morale

Morale is mixed across the teams. As discussed above, there is a degree of resentment, particularly amongst the medical staff, about the perception of risk management as a punitive tool. Many of the midwives struggle to manage care plans for women around the variation of practices among the medical staff. This is particularly evident during the ‘hot weeks’ and is impacting on the management of cases in the antenatal clinic. It was also reported that midwives do not always feel able to escalate concerns or disagree with the plans of care made by medical staff because such actions could be met with extreme hostility and for fear of being reprimanded in public.

12. FINDINGS AND CRITICAL APPRAISAL OF EVIDENCE

12.1 Strategic planning for maternity services across Devon

The assessors were informed of the future planning of maternity services for Devon. The plans have been reviewed very recently by an acute services review, under the auspices of the STP, in response to a very significant financial deficit across the health community. There is a commitment to maintaining a system with four CLUs, with NDHT being the smallest provider within the county.

It was not in the terms of reference for the assessors to consider whether this is an appropriate decision or not. However, the sustainability of the unit will depend on the quality of service, the needs and accessibility for the local population, the challenges of recruitment of all professional groups of staff and finally, the financial viability of the service. There was information from the executive team that aspects of the current service are under-budgeted (or over-spent) in the current financial envelope.

Within the network model it is clear that joint working with other Trusts is already occurring in cancer and neonatology services. Going forward, joint working may address many of the recruitment challenges through the creation of more imaginative career structures. Such imagination will be needed to recruit to an expanding consultant workforce, given the worries about the number of trainees failing to complete specialist training. These challenges will focus on obstetrics, anaesthesia and child health for a CLU delivered service.

The sustainability of the current model of care in providing both consultant and middle grade doctors to cover the few births per day at NDHT will be seriously challenging in the future and workforce planning should commence across the county of Devon to address these anticipated problems.
12.2 Quality of service

The metrics used to define the quality of clinical service are basic. Within a small unit, in which very high-risk women are referred elsewhere, the use of the traditional marker of perinatal mortality can be misleading. Clustering of cases and chance can distort such metrics. The assessors were surprised by the frequency with which the consultants used this outcome as the sole evidence of a safe service. The complacency of some consultants to the obvious errors identified through the SUIs was surprising and deeply disappointing.

Within this unit there appear to be recurring episodes of SUIs where the quality of care is below an acceptable level. The expectation would be that, with consultants potentially so close to the labour ward on a quiet unit, the rate of complications is very low. However, the reverse appears to be the case. Whether this reflects deskillig, disengagement, boredom, lack of escalation from middle grade staff or poor interaction with the midwives is unclear, but the assessors were repeatedly informed of incidents of tardy clinical decision making, questionable clinical competence, poor escalation of problems from middle grades and a failure to respond to strong messages from the midwives.

Other metrics of quality are comprised of the maternity dashboard and the Datix incident reporting log, including the identified SUIs. It is surprising that no medical initiatives have been developed to address the high rates of induction of labour and caesarean section. Most of the clinical incidents are documented by the midwifery staff. These issues provide additional evidence that the consultant staff appear remote from such fundamental clinical challenges. The investment of time from obstetric consultants into gynaecological services may be to the detriment of the quality of care in NDHT maternity services.

12.3 Working relationships within maternity services

There seems to be a serious breakdown in the relationship between the midwives and most of the consultants. There is a fundamental difference in that the senior management within the midwifery team are all relatively new to post at NDHT and widely experienced, having worked in several different settings. This group have introduced a degree of rigour and enquiry that is new to the Trust. In contrast, the majority of the consultants have been in post for much longer and are more resistant to change. Despite much external investment, these relationships continue to be the fundamental problem within the unit and may be responsible, on occasion, for the compromise of patient safety, seen in the review of the SUIs.

It was obvious to the assessors that the HoM and senior staff acknowledge the strong support and loyalty from the midwifery workforce (although that has not always been the case). The consultants feel that the HoM is far removed from the clinical workplace as most of their duties are in leadership or management. They believe that the HoM should spend more time being clinically involved. Such a view is not supported by the assessors who believe that leadership and management are the core responsibilities of the HoM.

Consultant staff seem to have little trust in the executive team. Their suspicious attitude was corroborated by the handling of the 2013 RCOG report where the consultants, with some justification, felt that the publication of the report was not handled in a transparent way.
Relationships within the obstetric medical staff have also been perceived to be tenuous, but there was an impression of ‘collusion’ within this group to try and maintain the status quo in terms of working practices. The assessors believe that the lack of genuine team working and mutual respect amongst some, are the principle determinants in the challenges faced by this unit.

12.4 Engagement with women and service users

It was difficult for the assessors to gauge if the women and their families are involved in any elements of service design. The assessors were not assured that active engagement of service users was appreciated and through listening to women and their families, did not feel that service improvement is on the agenda of the clinical staff. Most meetings concerning audit or clinical governance do not have lay representation or members of the Maternity Voices as regular contributors.

When talking to new parents in the labour ward, the assessors found them to be satisfied with the care they had received antenatally and during the birth, and positive about the care that they had received within the unit. None of the women that the assessors spoke to had complicated pregnancies or births. It was unclear how effective the Maternity Voices were or whether they functioned at all. It is worth noting that, despite requesting a meeting with the chair of the Maternity Voices or a lay representative, this was not arranged.

13. CONCLUSIONS

The RCOG review process at NDHT started with the analysis of several clinical incidents in maternity. During the interviews, staff made frequent reference to two further incidents, one of which had occurred very recently and had not yet gone through the formal review process. This particular incident raised very serious questions regarding appropriate decision making and clinical competency.

The assessors are well aware that adverse maternity incidents are not always avoidable or the result of poor performance or management. It is not possible to reliably assess the overall safety of a labour ward based on a few adverse outcomes. However, some of these outcomes would not be anticipated in a unit with such ready consultant involvement. Nevertheless, it is quite clear that safety within this maternity unit is guarded by labour ward midwives in particular, who act as advocates for women. The assessors were enthused by their dedication and passion, as well as their pride for the unit.

By contrast, medical staff (both at consultant and middle grade level) overall appear demotivated, over reliant on a single colleague on which all key responsibilities have been delegated, and somehow deskilled in labour ward practice. There appears to be a general shift of interest towards gynaecology, disregard for the unit obstetric guidelines and poor attendance at mandatory training sessions. Due to the nature of the unit, where a small number of births occur each year, such a situation is likely to continue to deteriorate.
There is a definite breakdown in relationships between medical and midwifery staff within the unit. While midwives try to act as advocates for women, medical staff view their attempts to bring practice in line to what is expected by Trust guidelines as an attempt to undermine their authority. Particularly evident is the friction between consultant staff and the HoM. It is difficult to see how this could be resolved without the introduction of a more dynamic workforce, adaptable to innovation.

The general reluctance from medical staff to follow unit guidelines is despite the guidelines (or at least those that have been shared with the assessors) being comprehensive, up to date and generally easy to follow.

No particular problems were detected in respect of escalation of clinical incidents at midwifery level. However, medical staff appear to be burdened by a blame culture where reporting of incidents is seen as an act of antagonism.

The governance mechanisms are complex and often do not include specialists in the investigation process. The result of this is that some of the investigations around the most serious events fail to identify the relevant factors and cannot therefore lead to appropriate shared learning and improvement.
14. RECOMMENDATIONS

The RCOG assessors felt that urgent action is needed if the senior leaders of the Trust are to guarantee long-term patient safety within the maternity unit and recommend the following:

14.1 Appointment of an external obstetric advisor, with the necessary leadership skills and appropriate support from the Trust board, which would allow them to support the existing Clinical Lead and Clinical Director in implementing change. The length and time required for such an appointment should be determined by the Medical Director and appointee, who should be accountable to the Medical Director.

14.2 Immediate consultant expansion, with the appointment of two to three new consultants with obstetric interest, appointed all at the same time, to inject new ideas and enthusiasm within the unit.

14.3 New appointees to be appointed across site with the Royal Devon and Exeter Hospital Trust, in line with the acute services review recommendations, in order to facilitate recruitment and create stimulating and rewarding job plans.

14.4 Enforcement of mandatory training across the unit and rotation of obstetric medical staff to the surrounding larger units for regular clinical sessions.

14.5 Radical changes to the consultant rota and removal of the obsolete 7-day ‘hot week’.

14.6 Involvement of human resource experts to review the long-term career aspirations and plans of existing long-serving consultants with a view to enabling retirement for those who are ‘burnt out’.

14.7 To reinforce and challenge the current appraisal and revalidation system for doctors within the Trust to ensure that the processes are robust and appropriate to maintaining clinical competences and decision making necessary for labour ward duties.

14.8 To deliver fair consultant job plans that are signed off by both parties within the time course set by the Medical Director, that guarantees quality for patients and maximum efficiency for the Trust in consultant and middle grade staff performance.

14.9 To plan medical staffing models that include consultant presence and anticipate the likely reduction of middle grade staff complement.

14.10 The participation of midwifery and obstetric staff in the investigation of ALL serious clinical incidents.

14.11 Transparent dissemination of the RCOG report to staff in its original version.
15. REFERENCES


16. SIGNATURES

In formulating and signing this report, we confirm that the conclusions and recommendations are based solely on the information provided, and on interviews that took place during the assessment visit as 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.

Mr Andrea Galimberti  
Date 1 December 2017

Dr Anthony Falconer  
Date 1 December 2017

Ms Mai Buckley  
Date 1 December 2017

Ms Coralie Rogers  
Date 1 December 2017

Ms Gerda Loosemore-Reppen  
Date 1 December 2017
## APPENDIX I: Interview schedule

**RCOG Invited Review – 27 and 28 September 2017**

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Time</th>
<th>Venue</th>
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<tr>
<td>Alison Diamond</td>
<td>Chief Executive</td>
<td>8.30-9.30am</td>
<td>Executive Office, Level 5, NDDH</td>
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<tr>
<td>George Thomson</td>
<td>Medical Director</td>
<td>9.30-10.00am</td>
<td>Executive Office, Level 5, NDDH</td>
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<tr>
<td>Darryn Allcorn</td>
<td>Director of Nursing, Quality &amp; Workforce</td>
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<td>Sharon Hinsley</td>
<td>Associate Director of Operations, Unscheduled Care</td>
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<td>George Thomson</td>
<td>Medical Director</td>
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<td>Darryn Allcorn</td>
<td>Director of Nursing, Quality &amp; Workforce</td>
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<td>Lunch</td>
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<td>12.30-1.00pm</td>
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<td>Tour of the Unit</td>
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<td>2.00-2.30pm</td>
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Thursday 28 September 2017

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<td>Midwives</td>
<td>9.30-10.00am</td>
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<td>Patient Reps</td>
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<td>George Thomson</td>
<td>Medical Director</td>
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<td>Darryn Allcorn</td>
<td>Director of Nursing, Quality &amp; Workforce</td>
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<td>Associate Director of Operations, Unscheduled Care</td>
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18. BIOGRAPHIES

Lead Assessor: Mr Andrea Galimberti – Consultant Obstetrician and Gynaecologist

Andrea has a Doctor of Medicine and is a Fellow of the Royal College of Obstetricians and Gynaecologists. Andrea undertook his undergraduate and general medical training in Italy, where he qualified at the University of Milan in 1992. Andrea was a Clinical Research Fellow in the Department of Obstetrics and Gynaecology of the University until August 1993 and then moved to the United Kingdom, where he undertook the Specialist Training Program in Obstetrics and Gynaecology in the South West Region. Andrea obtained the Certificate of Completion of Specialist Training in 2000.

In February 2001, Andrea was appointed as a Consultant Obstetrician and Gynaecologist at the Jessop Wing, Royal Hallamshire Hospital in Sheffield (part of the Sheffield Teaching Hospitals NHS Trust). Andrea is currently the Lead Clinician for Obstetrics and Labour Ward and the Clinical Director for Obstetrics, Gynaecology and Neonatology (since 2013). Andrea has special interests in high-risk obstetrics and labour ward management. Andrea is an Honorary Clinical Senior Lecturer for the University of Sheffield, Sheffield Teaching Hospital.

Co-Assessor: Anthony Falconer FRCOG – Consultant Obstetrician and Gynaecologist

Dr Falconer was the former President of the Royal College of Obstetricians and Gynaecologists. Before taking presidency, he was the RCOG Senior Vice President and International Officer. During this time, the RCOG raised its profile in international advocacy. Dr Falconer received his medical degree from the University of Bristol, and began training in obstetrics and gynaecology at the Simpson Memorial Maternity Pavilion in Edinburgh, Scotland.

Dr Falconer worked as a general medical officer in Kalulushi, Zambia, and was appointed registrar, and later a lecturer in physiology and pharmacology, at the University of Nottingham in the UK. While at Nottingham, Dr Falconer submitted a paper for his Doctor of Medicine degree, investigating sympathoadrenal responses in the fetus. Dr Falconer completed his final year of training at Groote Schuur Hospital in Cape Town, South Africa. In 1986, Dr Falconer was appointed consultant to the Plymouth hospitals. He made a major contribution, within the region, to the development of cancer services and hysteroscopy, by being a co-author in the first paper supporting the use of this technique in an outpatient setting. Dr Falconer was Clinical Director and Divisional Director Plymouth hospitals, where he maintained a major interest in training young doctors. In July 2012, Dr Falconer was elected Vice Chairman of the Academy of Medical Royal Colleges. During this time, he has also been the lead for the revalidation work.

During his presidency, Dr Falconer led the institution through a period of significant change in structure and function. He has been involved in producing three fundamental pieces of work; the Governance Review, High Quality Women’s Health Care and Tomorrow’s Specialist. These works will impact profoundly on the profession and on women’s services within the United Kingdom.

Dr Falconer retired in 2013 but has continued with quality assurance work for the RCOG and continues to be involved in a significant piece of work on the configuration of women’s services in Cumbria. Until 2017, Dr Falconer was secretary of the Academy of Medical Royal Colleges and continues to be involved in global health through the Zambia United Kingdom Health Workforce Alliance and the Scottish Collaborative for global health.
Co-Assessor: Mai Buckley – Director of Midwifery and Gynaecology.

In 1986, Mai qualified as a registered general nurse at Whipps Cross Hospital and in 1988, Mai qualified as a registered midwife at St Mary’s Hospital, Paddington, London. Mai was appointed as a Supervisor of Midwives in 1994 and in 1995 completed her Master’s Degree in Advanced Midwifery Practice.

In 1996, Mai took up her first midwifery manager position at the Whittington Hospital NHS Trust. In June 2000, Mai was appointed as Head of Maternity Services at Barts and The London NHS Trust. In April 2008, Mai took up the post of Director of Midwifery and Gynaecological Nursing at the Royal Free Hampstead NHS Trust which included the acquisition of Barnet and Chase Hospitals in July 2014 where she continues to be employed.

In 2005, following a request by the London Strategic Health Authority, Mai was seconded as the Head of Midwifery at Northwest London NHS trust (NW LH) for 2 days a week for 9 months, and again in 2011 for two days a week for 6 months at Barking, Havering and Redbridge Hospitals (BHRUT). This was to support the maternity services to implement robust clinical governance structures and address the key failures of the services following the implementation of “special measures” in the case of NW LH and the Care Quality Commission notice issued to BHRUT in September 2011.

Mai has maintained a passion for midwifery and delivers a safe effective service for women and their families. Mai has developed expertise in implementing and maintaining effective clinical governance structures in maternity services.

Co-Assessor: Coralie Rogers – Deputy Head of Midwifery

Coralie qualified as a midwife in 1989. Coralie worked at the Birmingham Women’s Hospital, initially as a labour ward co-ordinator before taking up the new post of Maternity Governance Lead in 2005. From here, Coralie developed and embedded good, staff-engaged governance systems across maternity and subsequently, as Risk Manager across all directorates, maintaining clinical practice throughout. Coralie has worked with Monitor to implement an improvement package at Milton Keynes, undertaken several external case reviews, including the Mid Staffs Review as a midwifery assessor. In 2015/6, Coralie worked at the University Hospital of Morecambe Bay, embedding service improvements across Women’s services, with a strong focus on service user and public engagement. Coralie is now working as an improvement advisor, most recently with Health Improvement Scotland in a review of maternity services at NHS Arran and Ayrshire. Coralie is a Care Quality Commission advisor and expert midwife developing the new national perinatal mortality review tool. Coralie maintains clinical midwifery experience at a local NHS Trust.

Lay Assessor: Gerda Loosemore-Reppen

Gerda has had a number of different, but not unrelated, careers. Educated in Germany and the US in Political Science, Philosophy, Education and German Literature to Masters level, Gerda started with funding social science research projects for the Economic and Social Research Council. This was followed by a period of social care research, performance monitoring, research and evaluation in the London Borough of Bexley, leading to the position of Policy Officer with the then Royal National Institute for Deaf People, now Action for
Hearing Loss. Gerda worked on service standards, research and policy developments. Subsequently, Gerda became a self-employed policy and research consultant operating primarily in the disability field, but also competing projects for the NHS, and local and central government departments. Gerda’s main interests are customer focus and disability equality.

In her work, Gerda has undertaken project-related visits, audits, practice and policy reviews, strategic planning and evaluations. This has involved a variety of field work situations, including observations, interviews, assessments, and public and patient consultations. Gerda has organised, run and evaluated focus groups as part of such consultation projects.

Gerda joined the RCOG Lay Group in 2007 and became Vice Chair of the Women’s Network for some 5 years or more during which time she familiarised herself with the key challenges in high-quality obstetrics and gynaecology from a patient’s perspective. Gerda became particularly interested in quality, ethical and safety issues, and in ensuring that the RCOG recognises that not all women are highly educated and able to communicate easily with clinicians, thus calling for communication in plain language and in a range of accessible media. Gerda represented the College on the Patients Liaison Group of the Academy of Medical Royal Colleges, also as a Vice Chair. These two roles terminated in June 2015.

Currently, Gerda is trained as an Enter and View Representative of her local Health Watch (Bromley and Lewisham) and a member of the Patient Participation Group at her local GP surgery. Gerda has become involved with the Patient Advisory Group of Bromley Clinical Commissioning Group and Bromley Health Care.