Review of the Obstetrics and Gynaecology services at Northern Devon Healthcare NHS Trust

By

The Royal College of Obstetricians & Gynaecologists

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1. INTRODUCTION

The review was commissioned by Dr Alison Diamond, Medical Director of Northern Devon Healthcare NHS Trust (NDHT), in order to assess the obstetrics and gynaecology services.

2. NAMES OF REVIEW TEAM MEMBERS

Lead Assessor:
- [Name]
  Consultant Obstetrician & Gynaecologist, Royal Free London NHS Foundation Trust

Co-Assessors:
- [Name]
  Consultant in Fetal & Maternal Medicine, Clinical Director for Obstetrics, St Mary’s Hospital, Manchester

- [Name]
  Local Supervisory Authority Midwifery Officer, East Midlands

3. REASON FOR REVIEW REQUEST

To obtain an external view of the impact of the medical team working on patient safety.

4. TERMS OF REFERENCE

(a) To review and provide recommendations to support future development of the obstetrics and gynaecology (O&G) service.

(b) To review the arrangements for the delivery of the O&G service at NDHT, to include:
- Labour ward presence and role of the consultant on labour ward, including the performance of other activities whilst rostered for labour ward.
- Elective caesarean section rates, including the impact of maternal request, and the timing of the lists.
- Fetal medicine: the appropriate level of service for North Devon, including the issue of maintaining competencies.
- Obstetric patient pathways, best practice and adherence to NICE guidance.
- The role of consultants in obstetric scanning.

(c) To advise on how the job plans of consultant staff within the service compare with units of a similar size, including equity and distribution of workload in O&G (including peripheral clinics):
- Current rota – provision of sufficient capacity in sub-specialty fields and continuity of care.
- Elements of the service that are provided outside the job plan (consultants, staff and associate specialist grade [SASG] doctors).
- Team working and alignment of consultant and middle grade rotas.
- Cover arrangements for leave.
(d) To consider the working relationships between consultant staff and between the medical and midwifery teams.
(e) Clinical engagement and leadership.
(f) Junior doctor support and training.

5. CONTEXT

The maternity and gynaecology service has always had excellent feedback from patients and good clinical outcomes, and continues to do so. The Medical Director’s request for a review was taken as a pro-active precaution because of her concerns about some functional aspects of departmental working.

In 2008–2009 there were seven serious clinical incidents investigated involving harm to babies born or to mothers. Themes and risks were identified from these, which resulted in an action plan, drawn up by the Medical Director and the Director of Nursing, to address relevant issues. The midwives were felt to be working autonomously, the doctors not working as a team, and the consultants not giving guidance to the SASG doctors, who make up the “middle grade” of medical staff (the department having no registrar-level specialty trainee (ST) doctors). There was felt to be a communication gap between midwives and consultants, with inconsistent treatment plans for patients. There was a perceived hierarchy among the consultants, with one later having time off work because of stress, feeling that she was not being listened to.

During 2010, the Medical Director updated the Trust Board on progress with these issues. A new consultant appointment was made in August 2010, with the role of Lead Clinician for the labour ward, also working in fetal medicine, and a process was begun to recruit a new Head of Midwifery.

In November 2011 the department was visited by the Postgraduate Dean for General Practice Training, triggered by concerns from trainee doctors, and an action plan was developed to address these issues. Further concerns were presented to the consultants in O&G by letter in December 2012 from the Director of Medical Education at Barnstaple Hospital. The issues raised included communication within the medical team, undertaking clinics without supervision, and access to the weekly education programme. A visit by the South West Peninsula Deanery Foundation School in May 2013 found the provision of training to be generally satisfactory, but with concerns regarding supervision, the use of paper-based handover processes, and the lack of formal induction for those joining the department.

In December 2011 and again in August 2012, informal and formal assessments were made and included The National Clinical Assessment Service (NCAS) involvement, which was completed in July 2013. The related actions recommended were the establishment of monthly consultant meetings, increased presence of consultants on the labour ward, and a review of consultant job plans (which has yet to happen).

A new Head of Midwifery took up post in January 2012.
In September 2012 the divisional structure of the Trust was changed, with a change of Divisional General Managers and Clinical Directors. As part of this, the Women and Children’s Division was
dismanded. O&G joined the surgical specialties division, and paediatrics, including the Special Care Baby Unit, joined the medical specialties division. The new structure also created lead clinicians for each department. Concerns were felt at that time about the functioning of the fetal medicine service, which was the sole responsibility of one consultant. There was also inconsistent practice with other obstetric ultrasound scans between obstetric consultants and radiographers.

In May and June 2013 two externally facilitated “Away Day” meetings of the O&G consultants and midwives were held to discuss the way the service functions and the strategic aims for the service.

There has been an ongoing dispute about working arrangements for the SASG doctors in the O&G service since 2010. This includes issues concerning inequalities in their contracted hours of work, arrangements for leave, wanting more time for continuing professional development activities, and confusion over their job titles. A successful business case in October 2011 increased the funded establishment of “middle grade” doctors from four to seven, with timetables to include experience in elective work. This was motivated partly in order to have their working hours compliant with the European Working Time Directive (EWTD) and with New Deal, and also to address safety concerns raised by the group of serious incidents (SIs) of 2008–09. These had all been related to labour ward and emergency gynaecology unit work, and it was felt that a greater opportunity to have regular elective clinical work would enhance the training and supervision of the SASG doctors by consultants. A group mediation meeting took place in March 2013, with the conclusion that a new rota should be implemented, with ongoing monitoring of its effectiveness. An appeal hearing in May 2013 found this decision to be appropriate and binding. Implementation, however, is still a matter of dispute.

The Local Supervising Authority Midwifery Officer visited in September 2013 and raised a number of concerns about practice.

In November 2013 there was a change in Lead Clinician for O&G.

6. DESCRIPTION OF REVIEW PROCESS AND SITES VISITED

The visitors requested, and were provided with a number of documents prior to the visit. The visiting team met on the evening of Sunday 17 November 2013 and shared out the documents received to read, summarise and discuss together.

Amongst the clinical audit data reviewed was that relating to amniocentesis procedures. These amounted to approximately 20 per year, undertaken by one consultant (the RCOG guidelines recommend a minimum of 30 per year to maintain practical competence). It was noted that a significant number of procedures had required more than one needle insertion, although no procedure-related pregnancy losses had occurred. The assistance with these procedures is provided by a healthcare assistant. Patients requiring chorionic villus sampling are referred to St Michael’s Hospital (Bristol) for the procedure.

The visitors then spent two full days at NDDH conducting a sequence of confidential interviews. The team also had approximately 30 patients’ case notes were available for perusal. The visitors were also taken on a brief tour of the relevant clinical areas in the hospital. At the end of the day on Tuesday 19
November 2013, the visitors held an informal meeting with Dr Diamond and senior managers to provide some very preliminary feedback from the visit, with the aim of submitting a formal written report in January 2014.

Subsequently, the visiting team had further e-mail discussions about the most significant concerns arising from digesting the information gathered from these sources. As a result of this, the Lead Assessor advised Dr Diamond and on 22 November 2013 that it would be prudent to stop any further amniocentesis procedures from being undertaken at Barnstaple Hospital, and that mechanisms should be urgently put in place to assess regularly the competencies of doctors undertaking early pregnancy ultrasound scans in the emergency gynaecology unit.

Interviews were held with the following staff/staff groups:

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- Trainee doctors, ST 1 and 2, in O&G and general practice
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- Supervisors of Midwives:
7. DOCUMENTATION SOUGHT FROM THE TRUST

- The management structure of the service
- Summaries of the investigations into the five clinical incidents in 2008–09, and the action plan which resulted from this
- Relevant clinical care protocols, including clinical referral networks in the region
- Job plans, job descriptions, curricula vitae, personal development plans, records of continuing professional development, appraisal records for all the consultants and specialist doctors in the department
- Analysis undertaken of these job plans by diary monitoring
- Working arrangements for the maternity and gynaecology service, timetable of clinics, other clinical sessions, and peripheral clinics
- Sample rotas from the past six months for consultants and other doctors, leave taken, the process for applying for and approving leave
- Workload statistics for the maternity and gynaecology service, including the reviews carried out of the maternity service and of the fetal medicine service
- The monthly maternity reports for the past six months, including statistics on elective caesarean sections and the indications for these
- Clinical governance information, audit reports of the maternity service, minutes of risk management and governance meetings for the past year
- Minutes of the two “away days” in May 2013 and June 2013
- A description of the financial claiming processes for duties undertaken extra to job plans
- Internal and external reports on junior doctor training in the department
- Any other information felt to be of assistance

8. SYNOPSIS OF INDEX CASES AND CONCERNS

The first sequence of seven serious untoward incidents occurred on 8 May, 10 May, 30 July, 7 September, 12 November 2008, 14 September and 7 December 2009. There were three cases in which serious illness (post-natal pneumonia, post-natal seizures, and severe pre-eclampsia) were not recognised as such, with resultant worse sequelae than might have occurred with prompter diagnoses. A baby developed severe hypoxic ischaemic encephalopathy following an excessively prolonged labour. The remaining three cases essentially involved the failure of community midwives to refer women for obstetric assessment, despite problems with pre-eclampsia, clinical suspicion of fetal growth restriction, and severe maternal obesity respectively, with resulting adverse outcomes.

More recently, in the year between September 2012 and September 2013 there were 43 clinical incidents escalated for further assessment, with four SLs requiring formal investigation. These included eight instances of complications at birth (e.g. shoulder dystocia, ruptured uterus, poor condition of the baby at birth), three cases involving missing swabs, two cases with intrauterine fetal death, one case with undiagnosed fetal anomalies, and miscellaneous incidents including missing drug cupboard keys, failure to undertake a pregnancy test before a cervical excision procedure, and failure to apply identification tags to a baby.
The common themes were inappropriate clinical decision making, non-compliance with policies and guidelines, and poor documentation and communication. Documentation provided to the visitors demonstrated detailed monthly reports of risk logs, but with no outcome or learning points completed. Clinical Risk meetings are held every two weeks, with the membership comprising the head of midwifery, a consultant obstetrician, the two lead midwives, the supervisors of midwives and the risk manager. It is not clear how relevant action is taken as a result of the discussions, nor how findings and recommendations are disseminated to other staff. There were, however, five clinical governance half day meetings held in the Medical Education Centre of the hospital during the year, with an average attendance of 32 staff, and usually five presentations of clinical audits or case histories.

9. GENERAL FINDINGS

9.1 Medical Managers Feedback

More than half of NDHT’s work (55%) is in the community (this excludes GPs) e.g. community hospitals and community nurses. The Trust is responsible for extensive very remote areas of North Devon. The population is almost all (99.98%) of white ethnicity. Average income is £3000 per annum below the national average, but much of the employment is temporary work, and the population in the Ilfracombe area is particularly socially deprived. North Devon has a good ambulance service, but travelling distances are significant (two hours to Plymouth, one hour to Exeter, two hours to Bristol). All women with identified significant medical problems are therefore booked to deliver in Exeter or the other main cities, and there are few misjudgements in this regard, with a very “risk-averse” policy. The main source of obstetric challenges faced in Barnstaple is from holiday makers, booked elsewhere, who go into labour early.

The PbR scheme of NHS funding is expected to result in a £2.2 million loss, equivalent to 20% of the annual budget for O&G. The change in divisional structure of the Trust introduced in September 2012 was intended to reduce the number of Divisions, because these were felt to be too numerous for a small hospital. The Division of Women’s and Children’s Services was disbanded. Obstetrics, gynaecology and midwifery moved to the new Division of Surgical Specialties, and paediatrics moved to the new Division of Medical Specialties.

Since the appointment of the Head of Midwifery in January 2012, the governance of the service has become more robust, with better investigation of clinical incidents. The Head of Midwifery is professionally responsible to the Director of Nursing for the Trust, and they meet frequently. Consultant appraisals in the Trust are conducted by appraisers from a different specialty, and this is ongoing work. There are no problems with midwifery recruitment. The current Clinical Lead for O&G is respected by all staff in the department and will work well with managers. There are two new business cases being considered now for outpatient hysteroscopies and for refurbishment of the antenatal and gynaecology outpatient clinic. The midwifery team do a very good job. The outcomes are fine. Achieving CNST Level 2 was good. All consultants are trained Educational Supervisors and the Clinical
Tutor role is taken seriously. The clinical risk process is fair and reasonable. All incidents reported are looked at by managers, who decide whether to escalate them to an investigation.

Concerns expressed included:
Inconsistent incident reporting, midwives tending to submit incident forms, but none completed by medical staff. There are questions about how the clinical risk group functions, and how recommended actions from the analysis of incidents are disseminated to other staff. The CNST process was not supported by consultant staff.

Concerns were expressed about team working and relationships between some individual senior staff, mediation had been necessary. Absence of Consultant meetings, staff groups working independently, and SASG doctors seem to work semi-autonomously with medical job plans difficult to understand. Supervision and accountability are not clear.

There is concern about the skills of some staff undertaking ultrasound scanning and related procedures.

9.2 Midwifery Managers Feedback

Approximately a third of women who deliver in Barnstaple have potential clinical risks including previous caesarean section, drug misuse, gestational diabetes (45 women per year), and social deprivation. The patients are geographically very widespread, and this precludes the designation of a midwife for teenagers, for example, because of the times involved in travelling between patients. Obesity and smoking are a major issue, and there is a poor standard of public health in the population generally, with high rates of illiteracy.

This is a cosy unit with warm-hearted midwives. The midwives are all very caring, women-focused, committed and hard-working. The midwives and SASG doctors have been here a long time, and work well together. All clinical guidelines are now on the hospital intranet. The data analysis we get back is excellent. Consultant presence on the labour ward has begun to improve on the past few months. There is a work desk for them.

Concerns expressed included:
Midwives put in incident reports, but medical staff do not. Some midwives are reportedly scared to complete incident forms, and there is resistance to the concept of risk analysis. Few consultants attend Clinical Governance and Risk meetings, and there was a lack of Consultant support for the CNST process.
Clinical care is not properly documented, guidelines are not followed. Existing guidelines are very idiosyncratic. There has been a lot of resistance to setting up a guidelines group.

There is a lack of cohesiveness, with no meetings between midwives and consultants. Midwives do not call consultants with clinical concerns, neither do the SASG doctors. The obstetric consultant on duty for the labour ward is there at the start of the day, but then it is the SASG doctors, although some consultants are more present than others.
Different consultants change patients’ care plans, which is very confusing, and there is a dissonance of views.

The midwifery supervision process is not understood, and has been functioning as pseudo-management.

9.3 Service Managers Feedback

It was acknowledged that the change in structure of the divisions has resulted in a change in management style, and that increased manager input would be beneficial, as the Division is large and there are many commitments.

Concerns expressed included a lack of team structure and some people working in isolation. It is felt that managers and consultants not working together, and there is poor attendance from Consultants at meetings. Concerns were expressed regarding inconsistency when women see different staff, and not enough supervision (of junior doctors by consultants).

The problem with the contracts for the SASG doctors and their rotas has been running for years. The change in management structure did not help progress to be made with this. A difference in perceptions has been revealed amongst the SASG doctors.

9.4 Consultant Feedback

It is a very friendly hospital, and staff all get on well. This hospital is safe, and we do not have complaints, and we produce good results.

When on call Consultants cover O&G. There is not a 40 hour presence of a consultant on the labour ward. There is cover, but not a presence. The labour ward theatre runs well, is safe and harmonious.

The Midwives are all excellent, and Consultants and midwives get on well. There are no major problems with staff relationships. Consultant offices are all close together, and we interact well. There are team meetings once a month, attended by all staff, and a lot of informal meetings.

It is a small unit, but we achieve a lot and in many areas we have introduced change including development of MAS techniques, full services in Urogynaecology and a Cancer Unit have been developed in the last five years. First trimester Down Syndrome screening has been provided since 2009, there is a VBAC clinic set up, run by a midwife, and all the maternity guidelines have been updated. We participate in national research trials, and the department has presented papers at the last RCOG Congress and at Colposcopy meetings. Guidelines are guidelines, there is no black-and-white, every patient is an individual. Consultant Job plans were changed when a sixth consultant was appointed and the arrangement of having a “hot week” on call was started. That raised problems with annual leave arrangements. All the problems raised previously by GP trainees have been addressed.
The SASG doctors are all experienced, but it was acknowledged that there is not enough clinical work to train all seven SASG doctors, and that training of the STs is the priority.

Concerns expressed included:
Some staff perceived that the level of risk management at NDHT is high, and the threshold for escalation is low. It is felt that this has led to staff feeling scared of incident forms and scared of litigation. There isn’t medical involvement in risk management, it run by the Head of Midwifery. There is a desire for more positive feedback.

Concerns were expressed about the change in Divisional structure, and the move of gynaecology beds to a surgical ward in another building, and there is a desire to have a General Manager for the O&G service. Some staff felt excluded from decision making. We submitted our work diaries to the Clinical Director but have heard nothing. A wish to see the Head of Midwifery more engaged in clinical work was expressed by some.

The organisation of the rota (i.e. the “hot week” system) means that junior doctors do not belong to a team, and staff groups are split from each other. It also creates problems with fulfilling waiting list targets. Consultants tend to work in isolation. Having skilled SASG doctors as a “middle grade” separates the consultants from the SHO’s teaching, and de-skills the consultants. The “middle grade” rota has been a long running problem, very difficult to sort out satisfactorily.

The Out-Patient Clinic needs to be up-graded. Concerns have been raised about the fetal blood sampling (FBS) machine for the past three years. Antenatal Clinics are over-booked, and have no allocated midwife.

The checking of competency of medical staff in ultrasound scanning is unclear. Scans are undertaken by medical staff as there are not enough radiographers to cover a five-day-a-week service. There is an issue about the level of sub-specialty work in which we can maintain the necessary skills.

9.5 SASG Doctor Feedback

SASG doctors feel that staff work as a team, and relationships are good with everyone, and results and outcomes are good. We have a fantastic group of midwives, who are very committed. The consultants are all very supportive. There is no problem calling a consultant if needed. Protocols are well applied. There is PROMPT training every month, The GP trainees work brilliantly, and O&G trainees learn to do elective caesareans, assisted by the SASG doctors.

Concerns expressed included: having sessions in the Emergency Gynaecology Unit whilst carrying the labour ward bleep. The hours worked by SASG doctors are too long, this is a concern for patient safety, and should change to 12 hour shifts. The seven-man rota, with 12 hour shifts, has still not been implemented. The distribution of duties in the rota is unfair and was seen to suit one individual in particular. We don’t meet each other much. The rota does not give opportunity for professional development, and there is no rotation between areas of work. We are not with a specific team to learn. The SASG doctors’ posts are considered as providing clinical service only, but there needs to be thought given as to how to motivate us.
Incident forms are processed by the Risk Management Team, and it is acknowledged that the midwives fill in incident forms, it is the Coordinator who fills them in. Some doctors stated that they had never completed an incident form, and it was expressed that in this hospital we do not need them (incident forms).

Minimal formal training in early pregnancy scanning, with no assessment of competence was raised, as was the loss of the gynaecology ward.

9.6 Trainee Doctors Feedback

Trainee doctors reported that the experience is superb with lots of hands-on experience. They advised that the SASG doctors are always very supportive encouraging and that the SASG doctors are experienced and approachable, but their knowledge of logistics (with the training programmes) is not necessarily so good. The College Tutor is very helpful. The consultants are all approachable. The interface between consultants and midwives is really pretty good. Trainee doctors also reported that the standard of midwifery is the highest seen in their rotation through the hospitals in the Peninsular Deanery.

Concerns expressed included difficulties with the Trust’ discharge summary system, as patients can be discharged without a discharge summary having been generated, and this then has to be done retrospectively. The SASG doctors are reluctant to do discharge summaries for women seen in the Emergency Gynaecology Unit, so we have to do them, even when we haven’t seen the patient. Consultants vary in their knowledge of our training needs. The loss of the gynaecology ward was of concern as well as the environment for patients undergoing termination of pregnancy.

9.7 Midwives Feedback

The weekly survey of patient experience, conducted by audit staff on the maternity ward, is consistently good, as is the feedback from community patients. We provide one-to-one care for women in labour. We have a reflective workforce, who seeks guidance from the supervisors. We have a good relationship with the consultants and the SASG doctors. We have no hesitation in calling them, and they are always available. Midwifery recruitment is not a problem, and the workforce is stable without recourse to agency midwives. We give good and safe care, and we’ve always worked well as a team.

We are very proud of the unit, and feel privileged to work here. Developments include creation of a Risk Manager post, the leadership role for Band 7 midwives has been built, and theatre nurses have been introduced in to “scrub” in labour ward theatre, brought in new resuscitaires, fibronectin measurement, and just have a new FBS machine.

Concerns expressed include the feeling of being under scrutiny and under the spotlight.
There has been a lot of change in the past two years, and the dynamics have changed. We do not feel supported by managers, and there is not a connection between the senior managers and the midwifery staff. The incident investigation process is not open and honest. It is felt that positive feedback is not given as in the recent example of not receiving any significant congratulations about recent CNST success. Lots of things could have been done right, but there is still criticism for leaving out one little thing. It leaves us feeling vulnerable and criticised. There is no midwife in the Antenatal Clinic, only a Maternity Care Assistant.

9.8 Gynaecology Nurses Feedback

This is felt to be a very good service, with very few incidents and very few complaints, and good relationships between doctors and nurses. We are proactive with clinical developments, such as with MAS and with Day Cases. Nurses are happy to complete incident forms if needed and there is a learning culture.

Concerns expressed included the loss of Gynaecology nurse expertise since the loss of the gynaecology ward, and the poor facility of the Outpatient Clinic area.

9.9 Allied Health Professionals Feedback

NT scans and anomaly scans are audited every three months. If there is suspicion of an anomaly, the patient is re-scanned by the Fetal Medicine Consultant within three days, or the patient goes to Bristol, if this Consultant is away. All antenatal and newborn screening complies with national recommendations, and we participate in the national audits, with our data all falling within the expected range.

There are very good communications with the Fetal Medicine Unit at St Michael's Hospital, Bristol.

Concerns expressed included Consultants who undertake NT scans do not participate in audit, and do not save their scan images. The image quality seems to be poor, and they are not undertaking enough to maintain the required skills.

Few amniocentesis procedures are performed (e.g. 12 from April to November 2013), and so maintaining skills is a concern. Radiographers only undertake scans in the Emergency Gynaecology/Early Pregnancy Unit one day a week, as there is not enough staff capacity to undertake more than this. The SASG doctors undertake early pregnancy scans at other times of the week, but there is no knowledge or checking of their competencies with these techniques.
10. CONCLUSIONS

i. The population served by the Northern Devon Healthcare Trust is that of a very rural community, with significant socio-economic difficulties, but without a high incidence of medical illness. The clinical outcomes and patient care provided by the staff are good. The clinical staff display great loyalty to the service and to each other.

ii. There is a sense of remoteness felt by clinical staff from the senior management, the Divisional Clinical Director and the Head of Midwifery.

iii. The conduct of the clinical risk management system is seen as punitive and negative.

iv. Team working amongst the medical staff has inadvertently been made difficult by the creation of the consultants’ “hot week” system and the shift working of trainee doctors and that planned for the SASG doctors.

v. The number of amniocentesis procedures undertaken at Barnstaple Hospital is insufficient to permit practical skills to be maintained.

vi. Some medical staff are undertaking early pregnancy (gynaecological) scans and Nuchal Translucency measurement scans (for Down Syndrome screening) without their skills in these techniques being tested and regularly reviewed and audited. The Lead for Emergency Gynaecology was unaware of the RCOG process (or any other) for establishing evidence of competence in ultrasound scanning.

vii. The role of consultants on the labour ward seems to be in keeping with that which would be expected for a unit of the size and patient population served by Northern Devon Healthcare NHS Trust. Similarly, the consultants appear to make an appropriate assessment of the spectrum of gynaecological work which fits the needs of their patient population, and participate actively in a number of relevant clinical networks in the South West Region.
11. RECOMMENDATIONS

1. Regular meetings and communications should be arranged between the Lead Clinician for O&G, the Head of Midwifery and the Divisional General Manager. Issues under discussion should be disseminated more effectively to the clinical workforce.

2. Consideration should be given to rebalancing the roles of senior Midwifery Managers, to include an element of clinical work.

3. Consideration should be given to recreating the Division of Women’s and Children’s Services. The style of management should recognise the culture, which is effective and natural for a small hospital serving a rural community.

4. The running of clinical risk management should be reviewed, with the aim of developing a more inclusive and positive culture with the issues discussed.

5. A review of the consultants’ on call rota should be considered, with a view to enhancing team working.

6. Amniocentesis procedures should no longer be undertaken at Barnstaple Hospital. Those patients requiring amniocentesis should be referred to the Fetal Medicine service at St Michael’s Hospital, Bristol.

7. All doctors undertaking NT scans and early pregnancy scans should have their competencies in these techniques formally attested and regularly appraised.

8. Competency in early pregnancy ultrasound scanning should be formally assessed for any member of staff performing ultrasound scanning within the Emergency Gynaecology Service.

Conclusions and recommendations are based solely on the information provided, and on interviews that took place during the assessment visit.